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ORIGINAL DEPARTMENT.

LECTURE.

PARALYSIS IN CHILDREN AND PARALYTIC CONTRACTIONS.

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Reported for the MEDICAL AND SURGICAL REPORTER by H. MARKS, M. D.

GENTLEMEN: To-day we will take up the subject of "Paralysis in Children."

This remarkable disease, which so gravely impairs the function of the extremities, and which is only observed in children, and which for want of a positive nature is termed infantile paralysis, or the paralysis of children, is also known under the name of spinal paralysis, but this last nomenclature I think is in advance of our present knowledge. However, it may be well to search for the cause of this disease in the spinal cord, but positive proof that we may find it there, is wanting. We may take for granted that with the first invasion, the disturbance is a diffuse one, that the brain and all its membranes are implicated; but what kind of process it is that acts so quickly, lies in darkness. It is remarkable that all traces of any irritation should disappear so rapidly that they cannot come under observation; but the disease is frequent, and we meet with many cases, etc. (here followed cases).

They are always small children that are thus attacked, from seven months until two years of age. Some of the children so attacked are dangerously sick, but only for a few days; sometimes we see distinct symptoms of hyperæmia of the brain, or if you please, meningitical symptoms, at other times severe eclamptic attacks.

Then again others will show only a slight indisposition, a little fever for a day or two, as it often occurs during this period of life without leaving any bad sequel, and without any possibility of knowing the cause of such fever.

Again, others are put to rest perfectly well in the evening, and apparently awake well in the morning, but to our horror paralysis has done its work during their sweet slumber. As a rule, and in the majority of cases, only one limb is affected, generally the right foot (monoplegia), very seldom one arm alone, but sometimes both feet (paraplegia), or a hand and a foot on the same side (hemiplegia), occasionally three, but rarely four extremities are affected.

Some contend that the hemiplegic form never occurs, or that what does appear as hemiplitic in children, does not come within the domain of paralysis of children, and from this they tried to prove that the nature of the disease was spinal. I think, however, they were mistaken, for we will meet with cases of hemiplegia that act exactly in every respect, and especially under the behavior of the electric current, as a mono-or paraplegic form. The affection, however, appears very often as hemiplegia, and one of the two extremities, the arm more often than the foot, gains its function rapidly again, and a monoplegia will alone remain, as illustrated in our first case. We also will meet with patients sometimes, where the quick development of a hemiplegia is hardly observed by the mother, and may remain so for a time; then the patient regains the function of his

limb without any treatment, though never perfect; one or the other limb will remain more or less impaired. This partial restitution is very characteristic in paralysis of children, but the greatest irregularity prevails; we are never able to tell with certainty how far this paralysis may be localized. (Explained cases.)

Not only in those cases where the paralysis is extended in the beginning over several parts from whence it disappears afterwards, but also in those cases where in the beginning only a single extremity has been attacked, the disturbance is more extensive, as we may have expected it to be, though later isolated muscles, or groups of muscles, may regain their function nearly perfectly.

The motor paralysis is in the beginning almost a total one upon the affected limb; later on, it restricts itself only to certain parts, and all this takes place quickly. In a few weeks we can decide which part will remain paralyzed and which will not remain so; and in those parts which remain stationary we cannot expect any improvement hereafter. And herein differs the paralysis in children from any other form of paralysis. We see then that it may occur that the muscles of a limb may remain paralyzed, and see that the reverse may be the case, they may all recover! This latter has been described as "temporary paralysis."

The sensibility is never disturbed in this peculiar paralysis of children. We are convinced of the truth of this by trying the electric current; small children will scream most horribly when it is applied. Neither the bladder nor rectum is affected, nor the sexual power impaired; for we will meet with paralyzed adults (paraplegia) which depends upon paralysis in childhood, who enjoy a splendid appetite for sexual indulgence; neither is the mental development retarded.

Therapeutics in this disease can accomplish nothing. If one should try to cure or relieve this affection, it would be only a hopeless attempt. We will not succeed in a single instance; even the so-much-praised electricity can accomplish little or nothing, no matter whether the inducted or the continuous current is employed; all is in vain after the lapse of a month. Right in the beginning isolated muscles, or groups of muscles, regain their function with the electric treatment more rapidly, but as far as I am concerned, I feel confident that they would have recovered spontaneously. Whatever does not respond after the existence of the disease of one month, will remain paralyzed forever, no matter what treatment we may institute. Surely this seems to be a sad confession. But it leaves a vast field open for the neurologist to explore; for us the main purpose of this lecture is to consider the surgical side of the question.

In no case, where the connection from the central organs to the apparatus of motion is separated, are such grave secondary disturbances developed so quickly as in this disturbance of children. And, first of all, a considerable general impairment of the nutrition of the affected member ensues, which begins to be very distinct in a few weeks or a month after the accident, that extremity is cold, has a bluish appearance, the pulse is weakened, the skin looks withered, the fat tissue disappears, muscles atrophy, the bones project, and the natural roundness of the limb is lost. The growth of the bones will not keep pace with the bones of the other side, the paralyzed limb will be in a more or less time shortened; and that this disturbance of nourishment and growth cannot altogether be attributed to the want of the use of the limb is evident. For we will meet with cases, for example, where, upon the foot only, but few muscles remain paralyzed, and the deformity is but slight, the child limps but little, and is playing about all day, but nevertheless the affected limb is far behind his fellow. And, in temporary paralysis, where the recovery is complete in all the muscles, still nutritive disturbance will take place, and will remain for the balance of life. These cases, therefore, are very valuable for the history of the diseases of children. Let us take especial notice of the fact, which deserves our attention, and the great extension of nutritive deficiency in every case, no matter how slightly a limb or a part of it has been attacked with paralysis, atrophy takes place over the whole extremity. We can trace it from the foot to the leg, from the leg to the thigh and pelvis, yes! even up to the shoulders and the head. The deduction from this is, that some of the muscles that were paralyzed in the commencement, regain their functions; but as far as the paralysis has extended, a certain amount of weakness does remain; these unfortunate children never recover completely from such a severe blow. Then, the secondary changes are added to this already impaired useful function. That is, the facets of the joints will be displaced; they will change their position into all kinds of abnormal forms; in short, the various kinds of club-feet will be developed—the so-called paralytic contractions. We have mentioned already that the paralysis will soon be stationary, and that the atrophy of the limb also reaches its maximum in a comparatively

short time, beyond which they do not extend. However, the bones show the greatest tendency of increase in displacement until the growths of the skeleton are completed. The majority of club-feet developed after birth depend upon that form of paralysis in childhood which I described. And as a general rule, a *talipes equinus* is developed; *talipes valgus* not so frequently, and a *talipes calcaneans* still less frequently, and the complicated form—*calcaneous valgus*—such as you see here, very seldom. Upon the knee and hip joint you can observe some slight changes of their mechanic form, and no contraction occurs here, even not in the severest form. But in the upper extremities, if they remain paralyzed, the fingers and wrist joint acquire a permanent position of flexion, but the elbow joint is exempt; in the shoulder joint, the function of motion is lost in that in that direction, which seem to be unnecessary for the paralyzed arm, that is, the elevation of the same. The pectoralis and the latissimus are more or less contracted. The foot receives the most unfavorable position; the deformities developed there are of a character that interfere the most; a paralyzed foot must be used to the best advantage, and many of those children so affected walk in time without crutches, though locomotion is imperfect, while a paralyzed arm is used but very little or not at all.

What are the causes of this paralytic contraction? How is it produced?

The theory which we find in most text-books is the so-called antagonistic, that takes it for granted that whenever paralysis produces deformities, the paralysis as always but a partial one. Those muscles not at all or very little affected draw the limb to their side; the shortening thereby is functional in the beginning, but in time the muscles will lose the power of extension, and this was termed *retraction*, to distinguish it from contraction. This is a simple theory; the question is only, What is the exciting cause that stimulates the non- or partially paralyzed muscles to a non-interrupted contraction? The exciting cause was believed to be the Tonus (tonic contractions), that the muscles were at all times in activity, and that continually a stimulus for contraction passes from the spinal cord to all muscles, even upon those apparently at rest; and when the function of the antagonist ceases the result would be the position of the part which they had maintained when at rest (explanation upon blackboard). Now, in regard to the voluntary muscles, the existence of a tonic contraction is certainly very doubtful; the surgeon, however, may leave this question at rest; for him it does not matter, whether a tonus, ever so small, does exist in the voluntary muscles or not. For him the question would be, whether the tonus of the non-paralyzed antagonist will be able to overcome the weight of the limb, or a part of the same. This would be necessary if the tonus theory is used for explanation of an abnormal position. Gentlemen, of such a power we do not speak; it is not present, and we may prove this by the single fact of the pendulous motion of the shoulder and the elbow joint, in the act of walking; the slightest change of the centre of gravity is followed by movement in these joints.

The slightly bent position of the elbow-joint, if the arm hangs down relaxed, does not depend upon the continuate drawing of the muscles upon the joint, neither that the flexor muscles are the strongest in action, as some have imagined, but it depends upon all the elastic extension which forms the joints and their surrounding parts. And remains after death.

Many others have written against the tonus theory as a production of paralytic deformity, and many of them have therefore fallen into errors with their substitutes. But there is one fact which we may think is self-understood, and cannot be denied, it is this: that a muscle may actively contract, but cannot actively extend itself. For instance, if the extensors of a limb are paralyzed, the flexors not, the limb will be in flexion as soon as the patient makes use of this muscle, and if the limb does not fall back by its own weight, or is returned by the hand or some kind of apparatus, it must remain flexed, and if it remains in that position for a long time a permanent flexion will be the result. (Explanation of facial paralysis followed here).

It is the foot that interests us the most to-day, and the antagonistic theory does not hold good here in all cases. If those that favor the theory would inquire whether in every deformity the limb is not turned always to that side where the muscles are not or partially paralyzed, they would find that the reverse is often the case. Let us examine carefully and we shall observe:

1. That in total paralyzation of all the muscles of the lower extremities, grave forms of club-feet may be developed. In total paralysis of the muscles of the forearm, we will find grave contractions of the hand and fingers only.

2. In non-complete, but wide-spread paralysis, both upon the forearm and upon the feet, are very often only those muscles paralyzed in preference, that are attached upon the concave side (the shorter muscles), while in accordance with

the antagonistic theory, the opposite should have been affected.

3. Even in distinct paralysis of a single group of muscles, the deviation may be found in the direction of the paralyzed side.

And this would prove to us that, at least in a great many cases, deformities are not produced by muscular power or tonicity alone. (Like in this case of talipes equinus before you.)

Now the position that the foot assumes, that is left to itself, and where all muscular power has been removed, is the same as we observed in deformities, and is produced by the influence of weight, which we have ample opportunity to see; for instance, in complicated fracture of the lower extremities, that have been treated in splints or suspension apparatuses, that do not fix the foot properly or support the sole, we will have a position of talipes equinus; and I called your attention to it, when we had fracture of the leg under consideration. This is produced, evidently, by the weight of the toes and metatarsal joint, which gradually sink down, and the shortening of the muscles and soft parts are secondary. This may also be produced by long continuance in bed without fracture. After this what has been pointed out, we certainly must attribute a good part of the mechanical influence as productive of club-foot. In a number of cases we see other and opposite forms of club-foot; how are we to explain this without the active assistance of the muscles? Again, how are the contractions produced upon the other joints? To answer this question, let the children walk and study carefully the way they do walk; look at the relation of the knee-joint; we will not find a perfect contraction there, even if the paralysis does extend upon the thigh, but on the contrary, the knee-joint is too movable, the thigh and leg forms an obtuse open angle (genu recurvatum); it is seldom in a high degree developed, except in exceptional cases, and then the knee may become perfectly dangling. In the hip-joint we find the same condition; we have always abnormal placidness of the capsular ligament, and we can produce upon the paralyzed side movements, that are impossible to accomplish upon the sound side, without producing pain.

A genu recurvatum is always accompanied with a relaxed condition or an incomplete paralysis of the quadriceps femoris muscle, and in complete paralysis of this muscle, a genu recurvatum may be produced, or the flexor muscles may maintain their full function, and then we have one of those cases, where the deviation is exactly towards the side of the paralyzed muscles; and that no contraction towards the side of flexion takes place under this condition is evident, for in the erect as well as in the recumbent position the extremities will fall on their own account and by their own weight in the position of extension, and the flexors of the knee will be sufficiently exercised without the help of their antagonist not to become shortened.

But how is this over-twisting and turning of this muscle produced? we may ask. We answer, shortly, that the patient, in the act of walking, does so, if possible, without the aid of the quadriceps; the walk is exactly like one whose thigh has been amputated and is using an artificial foot. (Explanation of mechanism of artificial limb was here given.)

We will also meet with cases where the patient in consequence of a sustained paralysis in early life, all the muscles that move the knee-joint remained totally paralyzed, and notwithstanding the walk without crutches. In others again, the extensors only remained paralyzed, and the function of the flexors was perfect; and many others, where only a more or less feebleness of the whole group of extensors exist, but the mechanic in the act of walking are all alike. They bring the paralyzed foot forwards, which in severe cases can only be accomplished by a swinging motion, whereby the weight of the body is thrown upon the knee, and brought into the extension, and is kept there. The leg can neither bend forward nor cave in behind, for anteriorly the weight of the body presses upon the planes of the joints of the femur and tibia close upon one another, and posteriorly the ligaments prevent the separation of the joint. Ligaments and bones must carry the whole weight of the body, and in consequence of this, the whole check apparatus must be injured; and especially on account of the general atrophy, the nourishment of isolated parts has been already impaired; and if you please, we may say the whole material of which this mechanical apparatus consists is not good. The ligaments in the knee-joint give way, and the bones abnormally burdened, become too low in front, the knee is overstretched or over-extended, a genu recurvatum is developed. This latter, if not in excess, is rather an assistance than an impediment in walking. Aud exactly the same conditions take place in the hip-joints. Then the cause of a number of paralytic deformities of the joints may be attributed to the fact that the patient can not use the simple movable segments of the skeleton, or cannot in a sufficient degree maintain their equilibrium by the muscles, and thereby drives the motion of the joint into its utmost limit, where the physiological

check apparatus interferes, and then with the help of the weight of the body, then the limb is at last useful as a firm and inflexible support.

The habitual scoliosis, the ordinary flatfoot, and genu valgum, depends upon the same cause, whenever bones or ligaments are burdened with weight, and work that should be performed by muscles, then these deformities are developed—in both the same mechanical conditions are present. If we now look back for a moment, we will see that we have three mechanical movements that are productive in the development of paralytic deformities:

1. The weight of the joints implicated.
2. The abnormal burden by its use.
3. The eventual inability to correct the position of the joint, that was produced by the motion of the non-paralyzed muscles; this last has the least influence, because the parts will be returned to their original position by their own weight, in the absence of their antagonist.

By the right combination of these three moments, each single case can be explained. The most frequent is talipes equinus varus; the most seldom, talipes calcaneous.

Let us say a few words of the upper extremities; here the same, the most intensely paralyzed muscles are the peripheric, and paralysis and atrophy disappear towards the trunk, and the most intense change takes places upon the hand and shoulder joint; the elbow joint is always exempt. This does not correspond with our previous perception, but it cannot be strange, for the arm hangs down extended in the elbow joint; in the act of walking, he sways forwards and backwards; in the sitting position the patient rests the arm upon his lap. How can a contraction be produced? But we may rest assured, if we meet with a patient who had paralysis as a child, and has carried his arm in a sling for a long time on account of the paralysis, that we may also meet with paralysis of the arm. We will also find a disturbance in the elbow joint; supination is lost or partially lost. Why? Because the patient, if the paralysis is very grave, so that he cannot use his hand, does not exercise supination; in a pending, useless arm the dorsal side of the hand is turned towards the front and outwards. This corresponds with a slight position of pronation. Such patient has no occasion to make use of his shoulder joint; the upper arm lies against the thorax, and elevation is not practiced. Therefore, the muscles, "pectoralis major, latissimus, etc.," are not developed; they are shortened or contracted (as you see in this patient here). A paralysis of the deltoid, "which elevates the arm," cannot be made out; if present, the contraction of the shoulder joint will be increased, "*but from no antagonistic reason*," and the muscles that run from the scapula, thorax and clavicle to the arm are paralyzed or feeble; then the weight of the arm will affect the shoulder joint especially, because the arm hangs down as a continuate weight, the ligaments give way, the head of the humerus sinks down, and sometimes so extensively that our finger can be deeply pressed between it and the acromion. This is often called atonic luxation.

The most prominent changes are shown in the hand. The fingers are flexed into the palm; the carpal joint is also slightly bent; extension meets with resistance; if we make strong flexion upon the fingers, we make passive extension, and the carpal joint will resist extension still more. The muscles and ligaments that run over the hand and finger joint are too short. Upon examination we find the flexors less paralyzed than the extensors, the last only may be paralyzed, or both sets may be so. Again, the extensors may be paralyzed; then the flexors or the last may be exempt altogether, and notwithstanding the contraction is towards the flexor side. This same phenomenon may be observed in fracture of the forearm where the dressing has been applied too tight. (Here followed cases in point.)

There can be no doubt, then, that contraction of the fingers, in paralysis of the muscles of the forearm, depends upon the position which the fingers assume upon itself depending; the fingers are not so heavy that they can fall into passive extension in the pending arm. They remain in a slightly-flexed position in spite of the pendulated motion of the shoulder and elbow joint in walking; this is a middle position, and depends upon the elastic tension of the ligaments and muscles, and the position of the planes of the joints, etc., etc., and this position remains upon the already putrefied cadaver. Upon the non-use depend all contractions.

In regard to the treatment, the mechanical support is the only remedy we possess; the various apparatuses I have explained to you already, and showed you the applications.

COMMUNICATIONS.

PREACHER-DOCTORS.

(FROM A REGULAR SUBSCRIBER.)

The subject of "preacher-doctors" seems to be attracting considerable professional attention at

present from various parts of the country, showing that this class of practitioners are either largely on the increase, or are becoming more aggressive and offensive.

It is no doubt high time that the question should be met, dispassionately discussed, and effectually disposed of. The ranks of the regular profession have become so overcrowded that all manner of tricks, schemes, intrigues, artifices, indeed every conceivable manœuvre short of an open, bold, flagrant violation of the American Code of Ethics, is resorted to by would-be reputable and regular physicians in their struggle for existence, for the impression the exercise of such diabolical diplomacy may make on an unsuspecting, harmless public.

It is not necessary for the enterprising newsgatherer or reporter to inconvenience himself in the least to interview this class of physicians: one of their daily duties is to hunt up a reporter and fill him up with news, having special reference to the great skill and ability of Dr. So-and-so. Positions of honor are vigorously sought after and from time to time advertised, together with little operations or attentions upon patients, in the public press.

One would suppose that a *preacher*-doctor would do the least to offend the Code of Ethics in the matter of public advertising; but some of the cutest, slyest, most cunning and most frequent advertisers I ever knew belonged to this class of physicians, which fact has, no doubt, among others, led the profession generally to believe that the pulpit is also used for no very pure purpose. They are unequalled in working up public presentations, and in appearing to be taken so completely by surprise when their presents are formally presented.

In a valedictory address a few years ago, Prof. Bartholow alluded in unmistakable language to this class of practitioners.

In a paper read recently before the Indiana State Medical Society on "Quacks and Quackery in Indiana," Dr. W. H. Lopp, of Columbus, Indiana, referred to them in no uncertain sound. And now comes Dr. A. L. Knight, of West Columbia, West Virginia, with a lecture on the same subject, which he delivered before the Ohio Valley Medical Society at Jackson, Ohio, May 10, 1883.

The following notes of Dr. Knight's lecture may not be uninteresting to your readers:

"Please notice that I use the word profession in the singular. I say, without fear of successful contradiction, that it is not within the intellectual capacity of any man to successfully and practically follow any two or more of the learned professions. He should give no more than, as it were, a recreative attention to the fine arts, politics, commerce, stock brokerage, agriculture, or, in fact, any of the active business affairs of life. If he give more than that, he has discounted his professional usefulness to the extent of the misspent time. One of Germany's favorite poets, the world-famed Goethe, was so well aware of the truth of this proposition, that he uses the following phrase in his sonnet to Art and Nature: 'Wer grosses will mus sich zusammenraffen, in der Beschrænkung zeigt sich erst der Meister"—He who would be great must concentrate; for in concentration only is shown the mas .

"It is said that the Hon. Daniel Webster in his boyhood asked his father what he should do to become great. His father, pointing to a nail in the floor, said: 'Fix your eyes and attention on that nail, and think of nothing but the nail, its composition, mechanism, and use, for ten minutes; if you can do that, you are already on the road to greatness.' Webster said that he tried it and failed; but it taught him one of the best lessons of his life: necessity of concentration.

"Now I have the highest respect for the man of God who walks in the footsteps of his Divine Master, who, with a contrite, humble heart, strives by constant meditation to learn the true mysteries of godliness; who searches the Scriptures in all their various reading, reads the multitudinous commentators who have labored in the same cause; who in fact devotes his best energies in the cause of his profession, and for no other motive than the salvation of souls. But for the local preacher with a secular business, who invades the sanctuary in a hypocritical spirit, and simply uses the pulpit as an advertising medium for his business, trade, or profession, I have the most supreme contempt. In fact, such rascals are beneath contempt.

"Thus I have endeavored to impress you with the idea of the necessity of concentration and a continued effort in any and all avocations, and especially in either of the learned professions, whose vast array of intellectual labor is enough, and more than enough, for the most gigantic minds of this or any other country.

"Writers on political economy urge a division of labor as the most conducive means to skilled labor. The truth of this proposition has very properly led to a division of the medical profession.

"You are doubtless aware that there is a class of physicians found here and there throughout the

United States, known and classified by naturalists as 'preacher-doctors,' a class of doctors styled by a professional friend 'medico-theological quacks, and the most diabolical frauds that infest society.' If the few specimens of these spiritual mountebanks which I have examined are representatives of their class, those epithets are not misapplied.

"Before proceeding in my analysis of these local specimens of hybridity, pseudo-preachers and pseudo-doctors, 'half-and-half,' I beg of you not to attribute my remarks to a spirit of jealous rivalship, for it is not the rivalry which induces me to speak of them, but the prostitution of the sacred cause of religion to the base purpose of winning unmerited favor and patronage, and their general inefficiency and hypocritical duplicity; also for the excess of confidence displayed by that class of physicians who no doubt have argued themselves into the erroneous idea that they are just the men to save both souls and bodies.

"Apologists for this class of physicians are wont to remind us that St. Luke, the evangelist, was styled the 'good physician,' and preacher-doctors themselves will deliver sermons upon 'the relations of Christianity to the practice of medicine,' based upon the text of 'Luke, the beloved physician,' in order to convince, if possible, the more intelligent and thinking portion of the populace, who cannot exactly see the propriety of a man pursuing both professions. St. Luke, we infer, was a practicing physician prior to his conversion, and we are inclined to believe that he discontinued the business soon after; be this true or not, the history of medicine informs us that the science of medicine in his day was but little understood, if we except the fact that, like our modern Lukes, the physicians of that almost barbarous age of the world knew how to charge for service rendered.

"I think it is Dr. Luke who tells us in his sacred writings of a lady who had spent all her *substance* among the physicians, and was not cured. Such things happen in our own enlightened age, but not with the same disease with which that woman was afflicted. Such afflictions are sometimes troublesome to cure; but in the hands of a skillful physician a cure generally follows, and the fees therefor are not excessive.

"A few years since I attended the funeral of a lady friend who had died of the same disease. The funeral service was by the gentleman who had rendered her medical service. I do not know what it was that prompted me to attend. You are aware, perhaps, that physicians as a rule do not like to attend funerals. But I did attend on the occasion referred to, perhaps out of curiosity to learn how the gentleman would likely succeed in the two professions. Well, in due time the doctor put in his appearance, dressed in the unexceptionable sacerdotal costume, even to the white neck-tie. He was so completely transformed, or disguised, that had I not known the reverend doctor I should have taken him for a preacher indeed, instead of the spiritual mountebank that he was. His countenance was that of melancholy personified, and seemed to be overflowing with sympathy for the relatives of the deceased.

"I thought his text was quite appropriate, which was, 'Behold, I come as a thief in the night.' These may not have been the exact words of the text, but they were something like that.

"It was his closing remarks that gave an increase to my disgust. Referring to the departed, he read from a slip of paper: 'Sister Jane Hyffman was born July 10, 1836, and died yesterday, aged thirty-eight years, five months, and eighteen days,' and then in a style of the greatest lachrymose: 'The Lord in his inscrutable providence has called her to mansions prepared for her. At this very moment she is casting her crown of glory at the feet of her Redeemer. Angel friends with harps in their hands are greeting her with smiles as she walks the jasper-paved streets of the New Jerusalem. Our loss is her eternal gain. The tears and prayers of her loving earthly friends could not stay the hand of the messenger sent by her Creator. Still, it is a great consolation to the weeping friends to know that she died firm in her faith in Jesus, and it is a further consolation to feel that all had been done for her that loving hearts and willing hands could do for her. The physician tried the best remedies known to the medical profession, yet God, in his mercy, called her hence. Therefore, my friends, watch and pray, for ye know not in what hour the Son of man cometh.'

"Now, that woman, in the prime of life, died under the treatment of that half-and-half rascal, who, had she been treated by a skillful physician, that is, one who gives his undivided attention to the study and treatment of disease, would doubtless have recovered. She had the same disease as that spoken of by the sacred writer, who had spent all her substance, etc., etc.

"I always admired the verse which reads: 'How beautiful are the feet of those who stand on Zion's hill.' But here, you see, 'distance lends enchantment to the view.' So you will perceive that the

No. 9's standing at the bedside of those sick unto death, to the exclusion of their superiors in the healing art, is enough to knock the poetry contained in those beautiful lines into a cocked hat.

"Our profession holds that a physician who resorts to any trick or artifice in order to bring himself into notice, is presumed to not have even ordinary skill, and is therefore guilty of quackery. Now, if the various self-imposed tasks which these gentlemen take upon themselves are not a means of advertising themselves, then what are they? I know of a certain professor of surgery at the capital of your State, who, when he has a little operation to perform, manages somehow to get a good crowd of the brethren in to witness the operation, and before beginning it says in a sanctified manner, 'Let's pray.' That is quackery in the high places.

"Again, these half-and-half fellows rarely or never contribute anything to medical literature. There was a preacher-doctor who resides in Fort Wayne, Ind., who contributed a paper on 'Gallstones' to the State Society, written, however, by a friend of his. After the transactions were published, he exhibited the article around among his patients for their admiration. Such doings as that the profession condemns as quackery."

Hospital Reports.

PENNSYLVANIA HOSPITAL.

SERVICE OF DR. R. J. LEVIS.

Selected Cases Reported by Dr. Geo. F. Souwers.

Varicocele.

In considering the treatment of varicocele you must recollect that there is an element, and at times a very decided element, of danger in performing the operations ordinarily in vogue for the relief of this affection. Not only is there the danger due to the inflammatory condition set up in the veins when these are ligated as in the common practice, but there is the further, and not less to be dreaded, effect on the testicle itself. While no actual acute inflammation may be set up in the testicle, yet it not unfrequently happens that a slow change takes place in the organ, which, if continued, eventually terminates in the emasculation of the individual so far as the testicle operated upon is concerned. In addition to this, where the button is employed, we have the sharp edges of the metal cutting into the integument, and proving a source of annoyance to the patient. Further, at times a higher degree of inflammation takes place in the veins, owing to the traumatism to which they have been subjected, than is necessary for their mere occlusion; in fact, this may go on to the occurrence of a pronounced erysipelas, which may involve the whole of the scrotum and surrounding cellular tissue. In all cases of varicocele we find a marked redundance of the scrotal integument, such a redundance that the testicles and the structures connected with them do not receive the necessary support. With this condition as a starting point, it is a question whether an operation that is not modern, having been performed by Sir Astley Cooper, but which has been lately revived, has not more claims in its favor than any of the so-called ligation operations; for, while in these the vas deferens and other tissues beside the worm bunches of veins intended to be sacrificed, may be included in the ligature in the hands of unskilled, inexperienced or careless operators, by means of this revived operation such accidents are impossible, or at any rate are minimized. The cardinal point aimed at is support of the testicle and the enlarged veins; if now we retract the scrotal integument we gain the desideratum aimed at. The question of how best to do this to leave such a quantity of scrotum as will just answer the purpose desired, and at the same time not to sacrifice too much, but to obtain an artistic, natural-appearing scrotum after the performance of the operation, is an important one. I think that by the employment of the clamp invented by Dr. Henry, we attain the desired results. The superabundant scrotal tissues being grasped by the fingers, are introduced between the clamp-serrated jaws of the instrument, it being well first to shave the surrounding tissues of hair. In order to avoid the inclusion of the tunica vaginalis in the portion to be excised, the integument about to be amputated must be stretched between the fingers, and light allowed to pass through. If translucent, the next step of the operation is proceeded with; if not, the undesired tissue is pushed out of the grasp of the instrument. All being right, the thumb-screw in the clamp is screwed down, the effect and object of this constriction being two-fold: first, hemorrhage is controlled by the pressure; and, secondly, the integument is held firmly from gliding or slipping away from the knife, which is now drawn along the convex surface or edge of the clamp. This edge being convex, the knife following it gives a circumferential scar or cicatrix on the lower and outer aspect of the scrotum. The superabundant skin having been cut off by any ordinary scalpel, sufficient sutures are introdnced to retain the edges of the wound in apposition during healing. The clamp is then removed, and the operation is finished. Healing takes place as in any ordinary skin wound, and the inconvenience and pain of daily tightening ligatures is avoided. The after-treatment consists simply in the employment of carbolized (1 to 20) water dressing, elevation or support of the testicles, and, if required, applications of the lead water and laudanum lotion.

As a companion picture to scrotal redundancy, I shall exhibit to you one where something similar obtains at the head of the penis, a condition that is provocative, in childhood especially, of various reflex irritations that find their expression in general irritability, masturbation, discharges, milky or cheesy in character from beneath the foreskin, wetting of the bed at night by unconscious urination, and in cases of older patients, by morbid erections and seminal emissions. In cases of unexplained and seemingly unexplainable nervous and dyspeptic states in boys, it is

always well to extend your examination to the sexual apparatus. If in later life many female troubles seem to originate in some morbid or diseased condition of the genitalia, the same rule may be said to largely apply to the male sex in the years of its early development, that is, as I have said, where obscure irritation is the source of the disease. When you find an elongated, tightened prepuce, that by the action of its mechanism is bound to retain secretions, and thus cause irritation, local and constitutional, it becomes your bounden duty to operate, and to remedy the defect *sufficiently*. Various means have been and are still pursued in order to accomplish the end in view. Heretofore it has been the custom to remove by means of the knife, at a single sweep, all the excessive skin and mucous membrane, the raw edges of the skin and mucous tissue being then brought into apposition by means of sutures. I do not, however, consider it necessary to proceed to this extremity. If we study the conditions carefully we find that, as a rule, it is not the skin, the integument, that is so much at fault, that this is not what acts so much as a constrictor, but that it is the mucous membrane that is at the root of the evil. The skin is freely dilatable, as any one may prove in his own person, not only so but it is in superabundance; whereas the mucous membrane, in the case of phimosis, is rigid, thus dragging down and holding the skin in its indirectly abnormal state. Such being the case, it is not absolutely essential that the integument shall be sacrificed, for if it be not bound down in position, it can readily be stripped back and ablution of the parts performed, it simply being the want of cleanliness that causes indirectly the reflex irritations. With this idea in view, and in order to simplify an operation that has sometimes resulted rather disastrously in some hands, owing to the forgetfulness of the operator of the great resiliency of the skin, I have invented what I style the phimosis forceps. Under the plan of amputation of the foreskin as generally pursued, it has happened that the skin having been drawn down too much and too much tissue removed, when the foreskin remaining left the hand of the operator it stripped back away beyond the point at which the foreskin should be found, much to the chagrin of both the surgeon and the patient. This forceps consists of two rather wide forceps blades articulated by a hinge and separable by means of a thumb-screw, and deeply serrated on the outer side of the legs. The narrow points of the blades having been introduced closed into the aperture in the foreskin, are pushed well up and then allowed to spring apart, or gradually screwed apart, the folds of mucous membrane falling between the serrations are caught and the instrument gradually withdrawn. The mucous membrane is thus brought out beyond the line of the integument sufficiently to be cut off by a circular sweep of the knife. The skin can then be stitched to the stump of mucous membrane, making a foreskin that can readily be stripped back.

The wound heals in a very few days; a few sutures are usually employed.

From the penis we will now go backwards and consider the case of Andrew R., 40 years of age, and married. For the past eighteen months this man has suffered pain both day and night, commencing with slight pain at the time of defecation, which pain lasted for a longer or shorter time after each act. It has gone on till the man is a physical wreck from the constant aching and shooting pain day and night, which deprives him of sleep even when under quarter-grain doses of morphia. He has not complained of the loss of much, if any blood, and his appetite has remained fairly good for a man in his condition. From the condition of his face and hands you see that he must have lost large quantities of flesh from the wasting and suffering through which he has passed. His stools, from being natural, have gone through various transitions, have been ribbon-shaped, but are now loose and wasting. On introducing my finger into the rectum I find about half an inch above the external orifice a hard, more or less nodular and annular mass, which is sensitive on pressure. What is to be done? There are but two operations for the man's relief; by one he prolongs life, voids his fæces by a painless artificial opening; by the other, he risks death on the table, but is radically relieved of the cause of his suffering. By the former the cause and hence the effect remain; by the latter he hopes to get more or less permanent relief; and, as he insists that he wants no temporizing, that life to him with this cancerous rectum is not only useless but absolutely distasteful, I have yielded to his wishes and will remove a portion of the rectum. The patient being etherized deeply, an elliptical incision is made that involves the whole of the sphincter muscle around its outer border. An instrument which consists of a series of sharp claws is now passed through the incision thus made, and reaching above the cancerous mass, is fastened into position by means of a sliding ring. The idea of this is that a hold is thus obtained on the gut, by which it may be readily drawn down. It is well to remember in excision of the rectum, that at the moment of excision there is apt to be very profound shock, so much so that it is at this time that death is apt to take place suddenly; and hence you must be on your guard. If it does happen, hypodermics of brandy, and heart stimulants, digitalis, etc., should be employed, hot bottles placed around the patient, and the head and shoulders depressed.

The gut being dragged down, the offending mass is cut off, involving, in this case, over two inches of the rectum, and being hard and gristly to the touch. The rectum must now be tightly packed with lint saturated with carbolized oil, in order to avoid hemorrhage as much as possible. The patient is wrapped in blankets, enclosing bottles of hot water, and has a hypodermic of one-fourth of a grain of morphia administered. The after-treatment will consist of tonics and stimulants with morphia, guarded by atropia, and nourishment of a fluid character must be administered every two hours. The urine will be drawn off by the catheter. Locally, lint and carbolized oil, and after some days rectal irrigations of carbolized water (one to twenty) will be used.

Reporter's Note.—This case progressed very satisfactorily from the first, nourishment was taken and retained, and the patient gained strength. There was a good deal of pain complained of for many days after the operation, it seemingly being,

by what the man described to me, rather spasmodic in character, and situated low down in the pelvis. The patient found more ease while in the lateral decubitus than when lying either on the face or back, still the pain was not of that agonizing character that it had been before. While at the time of the operation there was a good deal of blood lost, yet the hemorrhage was not comparatively nearly so great as I have repeatedly seen in operations of much less gravity, and I am not aware that he lost much subsequently to the operation. Dr. Levis, who saw the case long after I did, tells me that the curious point in the case is that the man is, or was when he last saw him, able to retain his fæces, that they were completely under his volition, and that altogether he might be considered a successful recovery.

The man not being a resident of this city, I have not been able to learn anything further of him.

NEW YORK HOSPITAL.

CLINIC OF PROF. WILLIAM H. DRAPER.

Reported by W. H. SEELYE, A. M., M. D.

Cardiac Hypertrophy.

The patient is a druggist, aged fifty-three years; married; has been a steady drinker; his father was subject to rheumatism, and he died with dropsy; his mother died of cancer of the stomach. Patient had his first attack of rheumatism at the age of thirty-eight, or fifteen years ago, in the knee and ankle-joints. He has had frequent attacks every two or three years since then; has had gonorrhœa, but no syphilis, and no malaria. One year ago he noticed that he began to lose his appetite and to suffer from dyspeptic symptoms, and he became short of breath on exertion. Four months ago his feet and ankles became swollen. These symptoms increased in severity, and two months ago he was obliged to give up work. He has now lost sixty pounds in weight, and complains of anorexia and palpitation of the heart, in consequence of which he cannot lie on his back.

Gentlemen, you have now heard the subjective history of this patient, and there is one point of interest in the family history, and that is, that his father was subject to rheumatism. In his own history we learn that he was a drinker; and also he has had attacks of rheumatism every two or three years. His general health was good until one year ago; but then it failed quite suddenly, and he began to suffer from dyspnœa, and other evidences of obstruction to the circulation. This history leads us at once to the probable seat of the disease. We will now examine him objectively for further information.

Inspection.—The patient looks older than he is; has light hair, now turned gray, and blue eyes; is of robust build, but the muscles are somewhat emaciated; he breathes through his mouth because of dyspnœa. A plaster of oil-silk and cotton, four by six inches, lies over the upper part of the chest. Respiration is mostly thoracic and labored. The abdomen is distended. The legs are slightly swollen, and the veins are somewhat varicose, and there is a mild eczematous eruption upon them. He lies in bed in a semi-reclining posture, with his head and shoulders propped up by pillows.

Palpation.—On tapping with the fingers at the side of the abdomen, a sense of fluctuation is appreciated by the hand on the opposite side. There is a diffused area of pulsation of the heart, and on expiration the apex beat can be distinguished at a point two and a half inches to the left of the nipple and in the sixth intercostal space, and so is much farther to the left, and a little higher up than normal. The legs pit on pressure.

Auscultation.—The heart beats rapidly. Over the third intercostal space at the left border of the sternum, a reduplication of the first sound of the heart is heard. And there is a sound like the crackling of a piece of leather, which is synchronous with the respiratory movement. It is evidently a friction sound, and is heard both on inspiration and expiration, and so must be a pleuritic and not a pericardial friction murmur. At the upper part of the right lung there is no respiratory murmur, though the chest moves freely. It is exaggerated on the left. Lower down on the right, the vocal resonance and the respiratory murmur are more distinct. At the base of the left lung there is absence of respiratory murmur, but a friction sound is heard.

Gentlemen, it will be interesting to seek the cause of this peculiar absence of respiratory murmur in the upper part of this man's right lung, although the chest expands freely. There has probably been, at some time, some consolidation of the upper portion of the right lung, as a result of bronchitis, or more probably in this case from an old pleurisy in which there was an exudation, which resulted in the formation of new tissue, which by gradual contraction has resulted in condensation of the lung, which in its superficial portions is thus made impervious to the entrance of air. It is important that you should know and recognize the signs of an impervious lung, which consist in an absence of the respiratory murmur, while you get an effort at breathing, and hear a faint murmur which seems to come from a point near the surface of the lung; but this sound has none of the characteristics of a true respiratory murmur. In examining the chest you must always have distinctly in mind the characters of the normal respiratory murmur, in order to recognize abnormal sounds; and if at any moment you forget them, you should go immediately to another part of the chest and listen until you get them fixed in the mind, and then return to the examination over the suspected region.

We have not yet completed the objective examination, but we have gone as far as we can here. It remains yet to inquire into the condition of the urine, as to whether or not it contains albumen or casts, and as to the amount passed, and the frequency of passing it. He says that he has been accustomed to examining it for albumen until two weeks ago, but he found none. But since he came into the hospital, it has been found to be present. The amount passed is considerably diminished, and its specific gravity is 1022.

Let us now briefly review the symptoms which we have elicited. They are, fluid in the abdomen, enlarged liver, spleen not made out, enlargement of the heart, shown by the displaced apex beat, friction sounds in the lungs, and pleuritic

effusions on the surface of both, and fluid in the lower part of the chest on the left side, and condensation of the upper part of the right lung, with expansion in its lower portion. These objective signs, with the subjective, lead us to the conclusion that there is dilatation of the heart, and as a result obstructive congestion of the kidneys and liver; though the evidences of portal obstruction are not pronounced. The hypertrophy of the heart depends either upon valvular lesions, or an adherent pericardium, the result of a pericarditis which may have followed some of his many attacks of rheumatism, fifteen or more years ago. So here again is brought to your notice a fact to which I have called your attention before, namely, that a man with heart disease may enjoy very fair health for a long time, and not be aware that there is anything wrong with his heart, until the period of compensation has passed. This man was apparently in good health until a year ago, although for nearly all of his life his heart may have been working against some obstruction, which was the result of an old pericarditis or an endocarditis. But now the compensation from hypertrophy has ceased, and the heart tissue, like all hypertrophied muscles, has undergone a degenerative change, and so has become weakened and dilated, and consequently no longer has force enough to overcome the obstruction in the circulation. As is usual, he first noticed an unusual trouble in breathing, on exertion, and then followed a succession of difficulties—general anasarca, peritoneal and pleuritic dropsy, and enlarged liver and kidneys. He has been in a pretty bad way recently, and was worse yesterday than to-day.

Patients often come into the hospital in a worse condition than this man, but under the favorable conditions of repose, good diet, and medication they get much better. They then go out again, and are quite well for a season; but from imprudence or over-exertion, they get into the same trouble again, and then they come back to the hospital; and with rest and the enjoyment of the same favorable conditions as before, their strength returns, and they so far recover that they again go out, only to return again after a time to repeat the same process. These patients, from their habit of coming to the hospital so often for the same malady, are frequently known as "repeaters."

So this patient, by reason of the advantages which the hospital offers, will probably improve and be more comfortable for a time.

Medical Societies.

Pathological Society of Philadelphia.

Case of Extreme Mitral Stenosis: Death Resulting in a Few Months from Sequential Lesions Without General Dropsy.

BY J. T. ESKRIDGE, M. D.,

Physician to the Jefferson Medical College and St. Mary's Hospitals.

Charlie, aged fifteen years, died in St. Mary's Hospital, during the latter part of December, 1882. In February of that year, during my term of service, he first came to the hospital, suffering from acute bronchitis. The attack ran its course in a week or two, but the heart, during and after the seizure, was exceedingly irritable, frequently beating from 120 to 150 times per minute. Infrequently he complained of pain over the præcordial region. The heart was repeatedly and carefully examined, but no endocardial murmur or pericardial friction sound was heard. No thrill or friction fremitus was felt. He was kept in the recumbent posture, and counter-irritants were applied to the præcordium. At the end of about two weeks he left the hospital feeling tolerably well, although the cardiac pulsations were rarely below 100 per minute, and a little exercise, or excitement of any kind, would increase them to 120 or more.

In August, 1882, he re-entered the hospital, and was again suffering from acute bronchitis, with free secretion, attended by numerous subcrepitant and large moist bronchial rales. After the subsidence of the attack, which took place in about a week, a decidedly rough and rather long presystolic murmur was heard. During the remainder of his life he stayed in the hospital, and was engaged most of the time in waiting upon the sick in the ward. Ascending and descending stairs, and active exercise of any kind, greatly exhausted him, causing the heart to beat tumultuously, and him to pant for breath. He rapidly grew worse, and by the latter part of November he was spitting quantities of blood rather frequently. The lungs soon became so engorged that the frequent hæmoptysis did not relieve them. During most of December he remained in bed propped up by pillows. The last two weeks of his life he was air-hungry, and gasped for breath. His extremities were cool and cyanosed, his face was of a dusky hue, and he expectorated large quantities of blood and frothy mucus. No general dropsy existed. Considerable albumen was found in the urine. Physical signs of pulmonary congestion and œdema, bronchitis, pleurisy with effusion, pleuro-pericarditis, and pericarditis with effusion in the pericardium, were present during the last few weeks of his life.

Sectio Cadaveris.—Numerous recent and old pleuritic adhesions were found, especially in the neighborhood of the heart. Pleuræ were slightly adherent to the upper portion of the pericardium by means of recent exudate. Considerable fluid, containing only a trace of lymph, and no pus, was seen in the pleural sacks. The pericardium contained several ounces of nearly clear serum. Several patches of recently exuded lymph were present on the outer surface of the ventricles. The weight and size of the heart were greatly increased. The right cavities of the heart were relaxed and filled with dark fluid-blood and a chicken-fat clot. The left side of the heart was less relaxed and contained a smaller quantity of blood. The wall of the right ventricle is nearly twice its usual thickness; its cavity is slightly enlarged. The right auricle is dilated. The valvular curtains at the pulmonary orifice appear competent, and show no inflammatory deposits. Tricuspid valve slightly incompetent, otherwise normal. The left auricle, with its appendix, is enormously dilated. The left ventricle is concen-

trically hypertrophied. The aortic valve curtains are somewhat thickened, but they are competent, and do not encroach upon the orifice. The mitral curtains are adherent to each other along their entire right borders, and along the external portion of their left free margins, thus leaving a space only four millimetres long by two wide for the blood to pass through. The valve has a leathery feel, but neither it nor the surface of the auricle is rough. The mitral valve does not present the funnel-shaped appearance usually seen in such cases, because, probably, the curtains had adhered to each other irregularly, and left the small opening to one side of the centre of the normal orifice. The lungs were dark, deeply congested, and more or less œdematous. Several ounces of clear serum were found in the peritoneal cavity. Liver, spleen, and kidneys dark and congested.

One point in the clinical history of this case is warthy of special attention. The first symptoms directing attention to cardiac disease, were the rapid pulse and exceedingly irritable condition of the heart. These symptoms existed for severel weeks, and probably for a few months, before a murmur was audible. An explanation of these, without the presence of a murmur, will be found by a careful study of the diseased mitral valve before us. Neither the valve nor the surface of the auricle is roughened, consequently, for the production of a presystolic murmur under such conditions, it is necessary for the blood current to meet with sufficient resistance in its passage from the auricle into the ventricle to enable it to set up decided vibration in the valve itself. Before sufficient mechanical obstruction took place at this orifice, the parts being comparatively smooth, to develop a murmur, inflammation and beginning adhesions of the curtains to each other were taking place. The latter conditions, although not sufficient to give rise to a murmur, rendered the heart irritable.

If the explanation given is the correct one, it points to the significance of some irritable hearts, where no murmur is present to announce cardiac valvular disease.

The length of the murmur was greater than that of any mitral presystolic murmur that I had heard before. It seemed to be divided into two parts, both occurring between the diastole and systole of the heart. The first part was the softer and had less intensity; the latter was very rough and ended abruptly. They corresponded to what Hayden has described as the post-diastolic and presystolic murmurs. He says they always denote great obstruction at the auriculo-ventricular orifice. The post-diastolic murmur, he thinks, is due to the passive flow of blood from the auricle into the ventricle; the presystolic taking place when the auricle contracts. If subsequent autopsies should almost constantly associate the prolonged or double presystolic murmur with great stenosis at the mitral orifice, it will be of value in prognosis, as life cannot long continue when stenosis is as great as seen in the heart I exhibit tonight.

Dr. F. P. Henry exhibited a specimen of intrathoracic aneurism, markedly sacculated, and involving the arch and descending portion of the aorta as far downward as the lower border of the sixth rib. The following notes were taken by Dr. Howard Kelly, the then resident physician, soon after the patient's admission to the Episcopal Hospital, December 7, 1882: There is a "distinctly elevated area about two inches in diameter to left of manubrium, occupying the first and second intercostal spaces, and projecting the cartilage of the second rib. This is also the seat of greatest dulness, and of strong bruit and expansile movement. Murmurs heard at apex, ensiform cartilage, and second right costal cartilage . . . . aortic sounds weak and muffled. Pulse in right radial and axillary, strong. In left radial and axillary, weak and distinctly delayed. Brachials at elbow visible, sinuous and atheromatous. Faint bruit in left axillary; none in right. Strong bruit in left carotid; faint in right. Same relation between subclavian arteries. Faint bruit in abdominal aorta. Left pupil always smaller than right."

Under the use of large doses of potassium iodide there was a decided subsidence of the external tumor, also of the pulsation and bruit. The most troublesome symptom, dyspnœa, was not, however, materially benefited. Death occured on May 13th, through rupture into the right bronchus, and was immediate.

The removal of the aneurism was rendered difficult by the adhesions to neighboring tissues, especially to the sternum and ribs in front. The fifth and sixth dorsal vertebræ were deeply eroded, and at the site of these erosions the aneurismal wall was entirely gone, its place being supplied by two masses of fibrin accurately fitting into the erosions, but unconnected organically with the sac. They merely acted as plugs. The heart was in an advanced state of fatty degeneration, and slightly enlarged. The aortic valves were perfectly healthy, but immediately above them were marked atheromatous changes. The opening into the right bronchus was about the *size of a three cent piece*.

Dr. Henry also presented specimens from a case of acute phosphorus poisoning, consisting of stomach, liver, kidneys, heart and spleen. The phosphorus was taken with suicidal intent during the night of May 7th, and was obtained by soaking the heads of a box of matches in water. Fifteen minutes after swallowing the solution the patient, a male German, æt. 22, experienced a burning sensation in the stomach, which in the course of a few hours (about six) steadily increased until the pain became excruciating. Copious and repeated attacks of vomiting then ensued, and followed every attempt to allay thirst, which was excessive. On the eighth, there was a very loose discharge from the bowels.

The patient was admitted to the hospital on the tenth. His skin was sallow and dark, but not then icteric in hue. There was tenderness over the liver, and the line of liver dulness was slightly increased. Severe pain in the abdomen was complained of, and this pain had continued with occasional intermissions since the eighth. The pulse was full and strong, 84 per minute. The temperature was 100°. The urine contained considerable albumen, but no casts nor other abnormal ingredients. I extract the following from notes taken by the resident physician, Dr. James S. Carpenter:

May 11. No pain; pulse 100; temperature 98⅘°. Patient refuses food but craves acid drinks.

May 12. Vomited once, but phosphorus not tasted by the patient as heretofore. Pulse 108 and weaker. Temperature which was 101° on the evening of the eleventh, now 98⅕°. Decided icterus. Thirst continues.

May 13. Jaundice increased; tongue dry and brown, red at edges; abdominal wall covered with numerous petechial spots; pulse 126; temperature 100°.

May 14. Intense jaundice; one clay-colored stool; pulse very weak, 32; temperature 98⅕°; extremities cold; bladder relieved by catheter; 48 ounces removed. The urine contained bile pigment in large amount, and had a very strong odor of phosphorus. The man died at 10.40 a. m., one week, less fourteen hours, after taking the poison. As the patient was not admitted until the third day after he had swallowed the phosphorus, the treatment was directed toward relieving pain and maintaining the strength as far as possible.

At the autopsy which was made very soon after death, the stomach was found filled with a grumous, bloody fluid, but the gastric mucous membrane was quite pale and free from erosion or any sign of inflammation. The folds of mucous membrane upon its surface were, however, unusually prominent. The liver weighed three pounds fourteen ounces. The anterior border of right lobe and the parts adjacent to the gall-bladder were yellow-mottled. Streaks of this yellow coloration extended along the borders of the fissures on the under surface; in parts these streaks were an inch in width. The bulk of the liver was normal in appearance; the gall-bladder was *empty*; heart rigid in systole; its valves healthy; slight pericardial effusions.

Lungs.—Some old pleuritic adhesions and emphysematous vesicles at both apices.

Spleen and kidneys apparently healthy.

Blood Fluid.—A microscopical examination of the liver will be made and reported upon at a future meeting.

(*To be Continued.*)

EDITORIAL DEPARTMENT.

PERISCOPE.

Leprosy and Beri-beri.

Dr. F. H. Enders writes an interesting letter from the Sandwich Islands to the *Louisville Medical News*, June 26, 1883, in the course of which he says:

The history of leprosy in these islands is very obscure. As far back as 1820, the time of the arrival of the first missionaries, we are told of the existence of a disease similar in nature to the leprosy of the present day; this was known among them as mai alii, or the disease of the chiefs. But among the first conspicuous cases after this time was that of a Chinaman, whereat the missionaries adopted the name of mai-pake, or Chinese sickness. Since then it has been known among the people by this name only, and from this fact it was supposed the disease originated among or was brought here by the Chinese, which I am not greatly inclined to believe; indeed, that the disease has existed among them from time immemorial seems to me the clearest inference to be drawn. What is leprosy? How often this question has been asked, and yet how unsatisfactory the solution. A few scientific men contend it is a form of syphilis; others, that it is a disease sui generis, greatly dependent on the habits and character of food; others, that it is of malarial origin, as stated by Sir Erasmus Wilson and my friend, Prof. L. P. Yandell; others, again, who are confident that it is caused by the inoculation of a specific bacteria. How, then, are we to reconcile these widely conflicting theories as to its relationship to syphilis?

Syphilis arises from the same character of sore, pursues precisely the same course, manifests itself in three different stages, here as elsewhere. If, then, it be akin to syphilis, it must be of some later form than the tertiary; then, if such be the case, why should this later form be inoculable, when I believe it is anaccepted fact among syphilographers that the tertiary form is not inoculable. As to it malarial origin, the fact of the great immunity suffered from this poison on these islands would rather preclude such an idea. If I were asked to describe a case of leprosy before reaching its last and most severe form, I would refer back to some reports made by Mitchell, Morehouse, and Keen, who had such large opportunities in the hospitals established during our civil war for diseases and injuries of the nervous system. The conditions they found to occur in the parts below the seat of injury were atrophy of muscles and various sub-acute inflammatory states indicated by tumefactions and congestions, edema, thickening of the cuticle, glassiness of the skin, cracks and fissures in it, eczema, curved and talon-like nails, retraction of the skin of the ungual phalanx, and exposure of the matrix, painful swelling of joints, and altered or arrested secretions. In addition to these, anesthesia, a bluish discoloration over the seat of anesthesia, and tendency to ectropion. Here we have a tolerably fair description of a case of leprosy. As it progresses, the anesthesia extends from its seat of beginning in the extremities, tumefaction increases, ulceration sets in, the flexor muscles strongly contract, the lobes of the ears and alæ of the nose are greatly hypertrophied, absorption of the bones of the hands and feet goes on, until some intercurrent disease or organic complication relieves the poor wretch and sends him to his long home. They are very liable to epidemics of phlegmonous erysipelas, the sequelæ being inflammation and suppuration of some of the lymphatics. I have operated on as high as fifty-four in one day from this cause, giving great relief to the poor victims.

There are now at the segregation about 700 inmates; the government has recently been very active in collecting and sending them to the hospital, until, in my district of about 6,000 people, we have not more than five lepers at large. But one white man has been condemned as a leper from this island since my long stay here, and he lived among them as one of them, eating from the same calabash, smoking the same pipe, etc. They are well cared for, having comfortable homes and plenty of food, and when once installed are loath to leave.

The description of a case, as given before, upholds very strongly the theory advanced by Prof. T. G. Richardson, of New Orleans, as being a disease of the trophic nerves; and the treatment by nitrate of silver seems to sustain it, as great good has resulted when it could be tried with any degree of satisfaction, the great trouble being their diet, which is composed largely of salt fish, this rendering the nitrate inert by converting it into the insoluble chloride. Salicylate of soda is the great remedy of the day; the future will tell us more of its effects. I learn Professor Gross has recently had a case from these islands. I should like very much to be allowed to forward you a sample case for your observation and study. We have another form of disease here that is doubtless a matter of curiosity to your readers, and that is beri-beri. I have seen about sixty cases on these islands, confined entirely to recent importations of Chinese, not one having been here over two years. This I attribute to the fact of the older residents adapting themselves to the diet and customs of the natives, dispensing with the excessively greasy and strong meats and fish that are brought from China, and eating poi, rice, meal, etc.

Dr. Simmons, of Yokohoma, from whom I have recently received a letter, refers in strong terms to malaria as a cause of this disease, yet Chinamen arrive here apparently in good health, and so remain for perhaps one or two years, when they are suddenly taken with the pain in the knee and flexor muscles indicative of the approach of beri-beri. It can not be malaria is the cause, for there is no country in the world which has suffered greater immunity from malarial diseases than this, unless some one eventually proves syphilis to be malarial. The first indication of the disease resembles very much that of progressive locomotor ataxia, the unsteadiness of gait, inability to stand with feet close together and eyes closed, the same difficulty in walking. But the phenomena which are generally to be found are summed up by Everard: debility, cold extremities, palpitation, dyspnœa on exertion, frequent, small and quick pulse, the bruit occasionally heard in the neck, scanty urine, torpid bowels, deadly pallor of the tongue, all indicating a condition of anemia. Treatment has but little effect, a large percentage of the cases being fatal.

The Fate of Peptones.

The *Med. Times and Gaz.*, March 31, 1883, says:

It is certain that we ought to search after some physiological principles more earnestly and constantly than we at present do. Outside the solid nucleus of acquired truth there lies a zone of fluctuating doctrine, which affords a more or less plausible excuse for disregarding in our daily practice some of the more important physiological questions. Much as the information is wanted, we are yet quite in the dark as to the nature of the majority of the chemical actions which go on inside the body. In the *Wiener Medizinische Wochenschrift*, No. 11, Professor Seegen's address before a recent meeting of the Medical Society of Vienna is recorded. The professor dealt with the greater part of the literature of the subject of the behavior of the peptones in the economy, and related some experiments conducted by himself. As all the medical world knows, the ingested proteids are largely converted into peptones by the combined action of the gastric and pancreatic digestions. Schmidt-Mülheim computed that at least three-fifths of the albuminoids were so treated by the digestive fluids. The manner of the conversion is by no means thoroughly understood. Kühne's elaborate researches clearly show that the metamorphosis is not a perfectly simple one. The immediate object of the transformation, looking at the highly diffusible nature of the easily absorbed peptones, is at once transparent, but the fate of the peptones on their arrival in the blood has yet to be thoroughly worked out. The investigations of Seegen may be regarded as attempts to resolve at least a part of this problem. Previous researches had made it highly probable that much of the hepatic glycogen was the result of the metabolism of proteid bodies. Seegen proclaims that he is the first to give the direct proof of the formation of a carbo-hydrate from an albuminoid body under the agency of the hepatic protoplasm. It is to be regretted that the experiments are not described in further detail. From the account given, we should be inclined to regard them as somewhat crude. Seegen's experiments seem to prove that by feeding animals with ready-formed peptones the amount of hepatic sugar is increased, that the liver is undoubtedly one of the principal seats for the conversion of the peptones, and that oneof the products of this transformation is hepatic glycogen. The main facts of the method adopted were to place a portion of a liver, taken from an animal recently killed, but kept supplied with oxygenated blood—on the one hand in a solution of peptones, on the other in simple water. After a certain time the amount of dextrose in each experiment was carefully estimated, when it was found that the preparation with the peptones yielded the larger percentage of sugar. The chief part of the address was taken up with the recital of the methods and results of previous workers in this department of physiological chemistry. We may mention that experiments made by Schmidt-Mülheim have proved that peptones injected into the circulation of animals exert a toxic effect on the cerebral functions; so that it would appear that the speedy metabolism of the peptones is a necessary factor for healthy life. However, the question is too intricate to be dealt with satisfactorily in the present state of our knowledge.

—A Sanitary Convention will be held at Muskegon, Mich., on August 23 and 24, under the auspices of the Michigan State Roard of Health.

Reviews and Book Notices.

Notes on Current Medical Literature.

—We have received a copy of an address by Reginald Harrison, F. R. C. S., before the British Medical Association at its recent meeting in Liverpool, entitled "On Some Recent Advances in the Surgery of the Urinary Organs." It was the address in the section of surgery, and is an admirable exposition of the late progress in this exceedingly important branch of surgery.

—We note the following reprints of articles by Dr. J. B. Mattison, No. 185 Livingston street, Brooklyn, N. Y., which may be procured by application to the author: "Neurotic Pyrexia, with Special Reference to Opium Addiction," "Opium Addiction Among Medical Men," "The Treatment of Opium Addiction," "The Curability of Opium Addiction," "A Personal Narrative of Opium Addiction."

—"The Country Doctor" is a pleasing little poetical effusion, from the pen of Dr. W. G. Brownson, of New Canaan, Conn. Coming to us as a reprint from the *New England Medical Monthly*, we have read it with pleasure and satisfaction. It is the annual address delivered before the last meeting of the Connecticul Medical Society.

—"The Management of Abortion" is the title of an article by Dr. Walter Coles, which comes to us as a reprint from the St. Louis *Courier of Medicine*. The author holds that it is better to let nature remove the placenta after abortion.

Book Notices.

The Essentials of Pathology. By D. Tod Gilliam, M. D., Professor of Physiology, Starling Medical College, etc. Philadelphia, P. Blakiston, Son & Co., 1883, pp. 296.

Pathology is greatly neglected by our busy practitioners, who look more towards the great practical departments of clinical medicine and therapeutics. Yet for the intelligent prosecution of the practice of medicine and for the beneficial application of our therapeutic resources, some knowledge of pathology is essential.

We cannot expect the busy physician to study the ponderous volumes on pathology, which delight the heart of the pathologist, but they can find plenty of time to read this book, which, as its name implies, contains all that is *essential* for the ordinary practitioner to know about pathology. We can heartily recommend this volume, and we would strongly urge all who feel that they are weak in pathology to buy and read it.

The Book of Prescriptions. By Henry Beasley. Sixth edition. Philadelphia: P. Blakiston, Son & Co., 1883. Price, $2.25.

This book contains upwards of 3,000 prescriptions collected from the practice of the most eminent physicians and surgeons, English and foreign.

While it is better, as a rule, for a physician to make his own combinations, yet such a book as the one before us will oftentimes prove very serviceable. Our own judgment is all the better for the assistance of that of others, and in many a trying, obstinate case, the anxious mind will be greatly relieved by the use of this book. Its arrangement is very good. First are given the drugs (alphabetically arranged) with a short description of each, then follows (under each) a lot of formulæ, their use indicated and the author's name appended.

We would suggest to the publisher, that while the price is reasonable, yet it is enough to warrant the cutting of the pages.

Transactions of the College of Physicians of Philadelphia. Third series. Vol. vi., 1883.

Most of the papers in this volume have appeared from time to time in our pages, but to any physician collecting a library, this book, neatly bound, will prove a very valuable acquisition. It contains a list of the officers and members of the college, and is in every way a valuable record of this old and eminently distinguished association of medical men. It is for sale by P. Blakiston, Son & Co., Philadelphia.

A History of Tuberculosis from the Time of Sylvius to the Present Day, Being in part a Translation, with Notes and Additions, from the German of Dr. Arnold Spina. By Eric E. Sattler, M. D., Cincinnati: Robert Clarke & Co., 1883, pp. 191. Price, $1.25.

Since the first notice of the expected publication of this work, we have looked forward to its issue with great interest; and now that we have examined it carefully, we hasten to advise others to do the same. The recent important researches on the cause of tuberculosis have lent a renewed interest to the subject, and justly created a desire to know something about the early history of this pathological process. Such curiosity will be amply satisfied by this little volume, and the reader will also find a good description of Koch's experiments with the bacilli of tubercle.

A Text-Book of General Pathological Anatomy and Pathogenesis. By Ernest Ziegler, Professor of Pathological Anatomy in the University of Tübingen. New York: Wm. Wood & Co., 1883.

This volume, translated and arranged for English students by Donald MacAlister, M. A., M. B., constitutes the July number of *Wood's Library of Standard Medical Authors*. The arrangement of the book, the division of the subjects and the style of the author, or rather the translator, are very good.

THE

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D. G. BRINTON, M. D.,
JOSEPH F. EDWARDS, M. D., } EDITORS.

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SEMMOLA ON BRIGHT'S DISEASE.

Some time since we had occasion to note the views advanced by Professor Semmola, of Naples, concerning the etiology of Bright's Disease. It will be remembered that he considers the primary fault to exist in the blood albumen, and to consist in such changes as render this albumen unassimilable, whence it becomes excrementitious and irritating to the structure of the kidney, which eliminates it, thus causing inflammation and subsequent structural degeneration of this organ.

Further experiments tend to confirm his views.

From the *Boston Medical and Surgical Journal*, August 2, 1883, we note his experiments as follows:

"Professor Semmola, following a line of experimentation instituted by him in 1850, injects subcutaneously in dogs and other animals abnormal quantities of albumen—albumen of egg, milk, blood-serum, abumino-peptones—and speedily renders them albuminuric. The animals are killed at different periods of the experimentation. When sacrificed twenty-four hours after the injection and absorption of an excess of albumen the kidneys presented no lesion, although the urine contained in the bladder was highly albuminous. This was regarded as a temporary albuminuria, and which, left to itself, would soon get well.

"When the animal was killed at the expiration of four days the kidneys were found hyperæmic. Sometimes veritable hemorrhagic infarctions were noted, even when the quantity of albumen injected was no larger than six to seven grammes per kilogramme of the animal's weight. On the tenth day there was a migration of leucocytes around the internal aspect of the capsule; the epithelia of the tubuli had commenced to degenerate fattily; the kidney was in the first stage of inflammation.

On the fifteenth day there was found to be marked augmentation of the inflammation, which kept on spreading, till about the twenty-fifth day the connective tissue fibres were seen to be involved, and the lesions of the first period of interstitial nephritis presented themselves. The ani-

mals shortly succumbed to the serious disorders produced by this experimentation.

"It was sought to demonstrate by these experiments that the injection of albumen of egg produced more speedy and more grave lesions in the renal organs than when milk or blood-serum was used. The nearer the abuminous substance used was like normal blood-albumen, the less irritating it proved to the uriniferous tubules. Professor Semmola has observed that patients in Bright's disease not only lose albumen in their urine, but also in all their secretions. If you cause them to perspire, their sweat is albuminous; if you give them pilocarpine, their saliva contains albumen in excess. Even the bile of these patients is albuminous. As a result of his experiments this writer concludes that Bright's disease is not essentially a renal affection, but a vice of nutrition, slow in its march, and produced often, if not chiefly, by suppression of the cutaneous respiratory functions, and characterized by an alteration of the albuminoid substances contained in the blood.

"This vice of nutrition prevents the albumens of the blood from being assimilable, and they are eliminated as foreign substances by all the emunctories of the economy. The kidney is only one of these emunctories. This organ, whose excretory function is of such preponderating importance, having a large proportion of this altered protein element to remove, readily suffers inflammation; but such inflammation and its consecutive degenerations are secondary to the blood vitiation and the profound constitutional disorder.

"Two of Semmola's experiments, communicated to Jaccoud, and published in the second volume of his Pathologie Interne, are so striking, and throw so much light on the question, that they are worthy of reproduction here. A robust man is suffering from Bright's disease *a frigore*. Semmola takes from him three ounces of blood, isolates the serum, and injects twelve grammes in the jugular of a dog, from which he had previously abstracted twelve ounces of blood. The urine of the dog became albuminous in two hours. Consequently, an albumen contained in the serum of the patient was in a molecular state, which rendered it unfit for assimilation. Thirty-five days later the patient is completely recovered. Semmola again takes from him a little blood and injects twelve grammes of the serum in the jugular of a dog; no trace of albumen is found in the animal's urine. Therefore, concludes this sagacious experimenter, the albumen of the first serum was, by the fact of the disease, altered and unassimilable; the albumen of the second serum has become, by virtue of the restoration to health of the patient, completely assimilable. Dogs are painted over their whole body with an impermeable varnish, and become albuminuric. The serum of these animals is injected in the jugular of other dogs, is not assimilable, and renders these animals temporarily albuminuric. The serum of healthy dogs, injected subcutaneously, or in the jugular, produces no such result."

If these results are substantiated, and we can ascertain the intimate nature and cause of this change in the albumen, and can devise some means of restoring it to its healthy condition, then have we made a great stride towards successfully combating this terrible disease, that is annually carrying off so many of our most useful citizens.

FRUIT IN SUMMER.

Nature clearly indicates that it would be well for man to make fresh vegetables and fruit his staple articles of diet in warm weather, and to relegate to the cold days of midwinter the heavy and cumbrous *roast*. No one denies—it is universally admitted—that fruit in season is very healthy, and should be freely used, but we must use judgment even here.

Fruit that will be good for one will not be wholesome to another. So reasoning, the following suggestions from the *Brit. Med. Jour.* are worthy of wide publicity:

"For diabetics, only the least desirable kinds, as certain nuts and almonds, are available; all others, as containing sugar, being forbidden. Sufferers from acid dyspepsia must select carefully, and limit their consumption to the least irritating

—few strawberries or a few grapes. Diarrhœa and dysentery preclude the use of all fruit. On the other hand, for constipated persons, it is sometimes the only reliable remedy which they can use continuously with comfort; it is also of benefit in renal diseases, by its action on the bowel. Atonic persons generally take it well, and feel the better for its digestive property. Those in normal health may eat almost any ripe fruit. The bland varieties are the most wholesome and nutritious—strawberries, apples, pears, grapes, and gooseberries. The last named, however, with currants and raspberries, are less wholesome than the others. Stone-fruits are apt to disagree with the stomach; but the more watery, as peaches and large plums, are better than the smaller and drier, as apricots and damsons. The pulp of oranges renders them heavy. Among other foreign fruits, bananas are wholesome. Dried fruits, and the skin of fruits in general, are indigestible. Nuts, the edible part of whic his really the seed, contain much albumen and some fat in a condensed form, and are particularly difficult of digestion. Fruit may be taken with a meal, or on an empty stomach. In the former case, it promotes digestion by its gently irritating effect on the mucous membrane of the stomach and intestine. If an aperient effect be desired, it had better be taken in the morning before breakfast or between meals. A succulent and pleasantly acid variety is best for both of these purposes, while it is also a food. The quantity of food which should be taken depends on the kind. If it belongs to the bland, nutritious class, a healthy person may now and then partake of it as freely as of any other wholesome food; but he will gain most benefit if he take only a little, and take it regularly. The same may be said of the invalid with whom fruit agrees. Cooking removes most of the acidity from crude fruit, and renders it lighter, as well as more palatable. So treated, it is productive of good and no harm; but it is a fundamental principle that whatever fruit is eaten uncooked must be fully ripe, and not over-ripe. This may sound trite, and indeed the principle is commonly admitted; but not, it would seem, by all, for we still find people, and not a few, who will themselves deliberately take, and worse, will give to their children, green gooseberries, green apples, etc., the very hardness of which, apart from their acid pungency, suggests their unfitness for digestion. Such people use as food an acid irritant poison, whose necessary action is to cause excessive intestinal secretion, with more or less of inflammation. Hence arises diarrhœa. On the other hand, fruit which is over-ripe, in which fermentation has begun, is a frequent cause of this disorder, and equally to be avoided, and perhaps also more difficult to avoid because the insidious beginning of decay is not easily recognized. It should never be forgotten by any who incline to follow the season in their feeding, that the want of such precautions as the above may produce that dysenteric form of diarrhœa, "British cholera," which is occasionally as rapidly fatal as the more dreaded Asiatic type of that disease.

SUGGESTIONS FOR THE TREATMENT OF CHOLERA.

In view of the possibility of an invasion by this disease, all that may aid us in combatting it will prove very valuable. Dr. T. M. Lownds, who has had much experience in the treatment of the disease, writes a somewhat lengthy communication to the *Lancet*, July 21, 1883, in which he strongly claims great benefit in the collapsed stage of cholera from the frequent administration of a form of nourishment which may be absorbed by the physical action of osmosis.

It is not offered as novel, but attention is again directed to it. The following is the formula which he has used for twenty-five years:

Mix eight ounces of recently-killed meat, chopped fine, with eighteen ounces of distilled water, to which have been added four drops of pure muriatic acid, and from half to a drachm of common salt. Stir with a stick, and after an hour throw on a hair sieve. When all the fluid has run through, half a pound more water may be added. In cases of emergency some of the red soup may be taken five or ten minutes after mixing. It should not be kept more than twelve hours in hot weather.

The doses must be small and frequently repeated, say a wineglassful every half hour.

In the same journal*, Dr Charles Egerton Jennings recommends the intravenous injection of saline fluids. Neither is this a *new* suggestion, since it was recommended by Dr. Little, many years ago; but it is well to refresh our memory on these points once in a while.

Notes and Comments.

Injections of Hot Water in Delivery.

Dr. W. Bain thus writes to the *Brit. Med. Jour.*, July 28, 1883:

"I can fully corroborate the remarks of Drs. Beckingsale and Boxall as to the utility of hot-water injections *per vaginam* in producing relaxation of a rigid and undilatable os, although, in such cases, chloral ought to be given, unless its administration is contra-indicated. There is not the slightest danger or discomfort attending the use of these injections. In tedious labors from defective expulsive power, warm-water enemata usually accelerate and strengthen uterine contractions, thereby hastening delivery; but I do not agree with Dr. Beckingsale that 'it follows that the hot enema must act as a direct and powerful stimulant to the uterine muscle.' I think it acts reflexly. As regards the injection of hot water in *post partum* hemorrhage, I believe it to be most unreliable, and I hope that, at no distant date, it will be entirely discarded. Dr. Boxall, in describing the treatment of a case of flooding after removal of an adherent placenta, where he had recourse to these injections, says: 'The administration of ergot, owing to the persistence of anæsthesia, was inadmissible.' What about the hypodermic injection of ergotin?"

And Dr. H. D. Pullan adds:

"Ever since the first mention, some years ago, in the *British Medical Journal*, of the American method of stopping hemorrhage by injection of hot water, I have adopted it with unvarying success, so that now I rely on no other method for post-partum hæmorrhage.

"A Higginson's syringe is all that is necessary to carry in the midwifery bag; and a small bottle of glycerinum acidi carbolici, or permanganate of potash, gives one the power of irrigating antiseptically at the same time.

"If labor have been prolonged, I always wash out the uterus this way after the expulsion of the placenta, and in this manner feel sure that in many cases post-partum hæmorrhage is prevented.

"I am surprised that more medical men do not use this method; they would if they once had tried it, for hot water is always to be had at a confinement, whether the patient be rich or poor. A long gum-elastic tube, with plain nozzle, is fitted to the Higginson's syringe, and the apparatus is complete for any purpose."

* *Lancet*, Sept. 23 and Dec. 30, 1882.

The Value of Moist-Sponge Dressing in Joint Amputations.

Dr. George McClellan contributes an article to the *Med. News*, August 4, 1883, illustrating the value of this dressing:

"After ligaturing the popliteal and sural vessels, the edges of the wound were carefully approximated with silver wire, and a large, soft sponge (previously soaked in carbolized water 1-40), was applied directly to the part, and held in position with broad bands of adhesive plaster, extending diametrically across the sponge and along the thigh, so as to exert equable compression upon the deep as well as the superficial structures. The ligatures were brought out at the most convenient points, and their ends embraced in the grasp of the sponge. There was no external or other dressing applied, except that a light roller bandage was run up the thigh to control muscular spasm, and the thigh itself slightly elevated upon a pillow of oakum. This dressing was not disturbed for twenty-four hours, when it was removed, and afterwards re-applied daily. One of two sponges was used alternately, and kept constantly moistened with carbolized water (1 to 40), while the other was soaking in the solution. At each removal, all the discharges were found within the meshes of the sponge, and the appearance of the wound was satisfactory, except upon the fourth day, when it became erysipelatous (from contamination of an outbreak in the ward). This was combatted by wetting the sponge with a solution of sulphate of iron (grs. x, aqua ℥ j), and the progress of the case was thereafter uninterrupted towards recovery, which was completed with firm cicatrization and entire cessation of discharges on May 20, three weeks from the date of operation."

Infantile Constipation.

While we know this to be a very common and a very troublesome condition to many physicians, yet we were hardly prepared for the numerous re-

plies which a query on the subject in the *Lancet* has brought forth. Some of them we have already given; we now note another. Dr. J. R. Seymour, in the issue of July 21, says:

"Well boil some coarse meal, stirring occasionally until the mass is reduced to a jelly (which will take some hours), then strain through muslin, and to the liquid portion strained off, add sugar to sweeten it; again boil to dissolve the sugar, stirring well the whole time to prevent burning; when the sugar is all dissolved it is ready for use, and can be kept warm on the hob. I am now able to state that my little patient is no longer troubled with constipation, his bowels being perfectly regular and healthy. Moreover, he is now contented, cheerful, has good nights, and is getting quite plump. A small quantity of milk (preferably Swiss) may be added to the food if necessary. I have found it advantageous to alternately change the diet to one of pearl barley, which is made in the same manner as the oatmeal. The oatmeal seems to rather overheat the blood (as mothers say), and causes a rash at times like strophulus, which, as far as I have been able to judge at present, may be obviated by varying the diet as proposed. As to oatmeal being a cause of rachitis, all I can state is I have not noticed any signs of it at present. In the meantime I shall continue the meal, and for children whose stomachs will not tolerate milk in any form, I consider meal is *the* thing."

The Sanitary Lessons of Indian Epidemics.

Since these lessons are not confined to *Indian* epidemics, but may be profitably remembered in connection with all epidemics, we transpose them from an address by Dr. Cunningham (*Med. Times and Gaz.*, July 21, 1883).

1. The importance of ascertaining the facts, both those respecting the localities immediately concerned and the general history of disease at the time, and of recording them *all fully*, instead of recording only those which tell either on the one side or on the other.

2. Having collected *all* the facts, we must assume nothing, and draw from them no conclusions except such as are strictly logical.

3. That, however the questions may be affected by further research, the doctrines of germs or contagia communicated from the sick to the healthy will not account for Indian epidemics, and especially not for epidemics of cholera and prevalence of enteric fever among European soldiers serving in India.

4. That to diminish fevers of all kinds, to diminish cholera, and to diminish small-pox—the three greatest forms of Indian disease—the real and only practical remedy is the improvement of local sanitary conditions, largely aided in the case of small-pox by vaccination.

Case of Cutaneous Calculus.

The *Med. Record*, July 28, 1883, says: Dr. G. W. H. Kemper, of Muncie, Ind., sends us the following report: "On May 9, 1878, I removed by incision one of these rather rare morbid specimens. The patient, a lady, aged fifty-five years, stated that about twenty years previously a small tumor developed in the right eyebrow, and gradually grew to the size of a hazel-nut. She had experienced no pain from it until the last year before its removal, when its presence became rather annoying, and at times caused neuralgic pains by pressure upon the supra-orbital nerve. It probably began as a sebaceous cyst, and eventually was transformed into a calcareous mass. I was uncertain of the character of the tumor until my knife came in contact with the stone. It is of an oval shape, rough surface, and weighs at this time seven grains. No further trouble was experienced after its removal."

Psoriasis and Other Diseases Associated with Vaccination.

Dr. Wood (*Journal of Venereal and Cutaneous Diseases*, Vol. i., No. 6), after relating the histories of two cases, in one of which eczema, and in the other psoriasis, disappeared coincidently with vaccination, relates two others in which psoriasis developed after vaccination. The latter two patients were sisters of the patient (a man, aged 20) who lost his psoriasis after being vaccinated, and therefore presumably belonged to a psoriatic family. They were aged respectively eight and nine years, and had had previously no sign of psoriasis. In the spring of 1881, they were vaccinated with bovine virus of the same stock as that used in the other cases. With the subsidence of the vaccine disease, each one of these girls had an eruption of psoriasis, which has now lasted nearly a year.

Gall-Stones in an Infant.

The *Boston Medical and Surgical Journal*, August 2, 1883, says that Dr. A. D. Walker reports the case of an infant three months old, and healthy, who, when it was one month old, had an attack of icterus, and who, after some hours of restlessness and suffering, passed by the rectum, a purgative having been given, three gall-stones, the largest of which weighed two grammes.

SPECIAL REPORT.

NO. XIV.—OPHTHALMOLOGY.

BY CHAS. S. TURNBULL, M. D.

Elephantiasis of the Lids—Convergent Strabismus—Osteoma of the Orbit—Pulsating Exophthalmus—Traumatic Herpes of the Cornea. Neuroparalytic Keratitis—Malarial Ocular Affections, etc.

(*Continued from page* 195.)

Lawson, G. *Ectropium of the Upper Lid Remedied by Transplanting a Piece of Skin from the Arm.* The Lancet, January, 1882, p. 13. Lawson operated for ectropium by transplanting a piece of skin from the arm, with good result.

Abadie. *De l'Autoplastie des Paupieres.* L'Union Méd., 1882, No. 8, p. 87. In a girl, 20 years old, an ectropium was formed after an extensive destruction of the skin, the forehead, and the temple by burn. The edge of the lid was freed by a cut six cm. long, and a piece of skin taken from the arm transplanted into it, which healed in well. The author advises to keep the transplanted flap warm during the first forty-eight hours.

Rampoldi. *Fimosi e Ptosi Palpebrale Congenita Atropica.* Ann. d' Ottalm., vol. xi., p. 31. Rampoldi reports a case of congenital phimosis and ptosis. The muscles of the lids were completely atrophic.

Teillais. *Elephantiasis des Paupieres.* Arch. d' Ophth., vol. ii., No. 1, 1882. In a woman 75 years old, a large fluctuating tumor of both upper lids was found, which hung down upon the cheeks. It contained a serous fluid. Both tumors were excised. The microscopic examination showed reticulated connective tissue, with small and large meshes. Atheromatous degeneration of the blood-vessels; marked development of the lymph-vessels, and around them an infiltration of round cells.

Theobald. *What Constitutes Insufficiency of the Internal Recti Muscles?* Amer. Jour. Med. Science, April, 1882. T. has found a degree of insufficiency, ascertained by means of the vertical diplopia test, in a large number of eyes where there was no complaint of asthenopia. He is at a loss to know where to draw the line between normal and pathological insufficiency. He therefore concludes that a very considerable divergence (even of 22° for the vertical line dot test of Gräfe) does not of necessity indicate a pathological insufficiency of the int. recti.

Stelwag. *Papers on Practical Ophthalmology.* Complement to the text-book. Vienna, 1882, No. 7. Genuine convergent strabismus must be explained as an excess of convergence, which latter naturally is coördinate to the accommodation, practiced to reduce the great strain upon the accommodation, and gradually becomes a habit; this excess of convergence is voluntary, though not practised from choice. The result of the squint-operation, in many cases so brilliant, is really not a true cure, but a masking of the affection.

Tessut. *Recherches sur le mode de Cicatrisation du Tendon après la Strabotomie.* Rec. d' Ophth., February, 1882. After the tenotomy of a muscle, the end of the tendon again attaches itself to the sclera by means of fibrous bands, more seldom to the conjunctiva. Care should be taken in dividing the tendon of the internal rectus, as the muscle withdraws to a considerable degree.

Boucheron. *De la Cure du Strabisme Convergent Intermittent par les Mydryatiques ou les Myotiques.* Arch. d' Ophth., vol. ii., No. 1. Atropine treatment is useful in beginning of periodic convergent hypermetropic squint, as it paralyzes the accommodation, and thus prevents the tendency toward excessive convergence. The atropine cannot be dispensed with, until not even a momentary strabismus is apparent when looking at an object held close. Glasses completely correcting the hypermetropia should then be worn. Eserine may be given at the end of the atropine treatment, and in those rare cases in which convergence increases under mydriatics.

Morano. *Contribuzione alla Patogensi dello Strabismo Ottico.* Giorn. delle Malatt. Degli Occhi, vol. v., February, 1882. Convergent squint in a child twenty days old, five days previously a violent catarrh of the lachrymal ducts and the conjunctiva had set in. The squint did not disappear until two months after the inflammation had ceased. The author thinks that an inflammation of Tenon's capsule was the cause.

Coppez. *Neoralgie, detante de vingt ans, guerie par l' élongation du nerf sous-orbitaire.* Ann. d' Ocul., January, February, 1882, p. 59. A miner aged fifty-one years, had suffered from *neuralgia of the right side of the face for twenty years,* which had resisted all remedies. It was *cured by stretching the infra-orbital nerve.*

Imre. *A Rare Case of Osteoma of the Orbit.* Centralbl. f. A., 1882, p. 41. The author saw an osteoma of the orbit in a woman sixty-two years old, 8½ cm. long, 6½ cm. thick, 6 cm. high. It was said to have existed for forty-two years, and had so displaced the eye that the cornea was on a level with the corner of the mouth. The tumor was cast off spontaneously after an inflammation which lasted a year. Healing was good, and the eye almost regained its original position.

Teillais. *De quelques tumeurs de la region orbitaire.* Ann' d' Ocul., January, February, 1882, p. 44. In a man, thirty-two years of age, a cyst developed from the frontal sinus, which dislocated the left eye downward. After its removal the eye again resumed its normal position; nothing remained but a scar in the supra-orbital region. In a young man of nineteen years, an ivory tumor sprang from the frontal sinus, which dislocated the eye downward. As the tumor had a broad base, it could only be partially removed.

Dor. *Kyste Congenitol de l'Orbite, Microphthalmie, Colobome de l'Iris et de la Choroide.* Rev. Gener. d' Ophthalm., 1882, No. ii., p. 81. Dor describes a *congenital cyst of the orbit*, which was complicated with microphthalmus; the eye had a coloboma of the iris and choroid.

Eales. *Pulsating Exophthalmus, with Paralysis of Third, Fourth, Fifth, Sixth, and Seventh Nerves, and Blindness from Absolute Glaucoma Following Severe Crush of the Head.* Birmingham Med. Rev., January 4, 1882, p. 46. Probably fracture of petrous bone and rupture of internal carotid.

Lewkowitsch. *Two Cases of Interstitial Keratitis.* Zehender's Monatsbl., vol. xx., p. 12. In a case of gastritis, Lewkowitsch observed the occurrence of interstitial keratitis, which grew better or worse according to the state of the former. Iodide of potash cured the whole affection. In another case interstitial set in. Here a quotidian intermittent fever was followed by a chronic gastric catarrh.

Pfluger. *Specific Parenchymatous Keratitis.* Ophthalmic Clinic of Berne University. Rep. for 1880. Berne, 1882, p. 31. As soon as the most severe symptoms of irritation have disappeared, the author advises in specific parenchymatous keratitis the use of a vaseline salve (0.5%) of the yellow oxide of mercury, gradually increasing its strength to 3%.

Colsman. *Case of Recurrent Affection of the Cornea in Gonorrhœic Arthritis.* Berl. Klin Wochenschr., No. 16. Colsman observed in a gentleman who was troubled several times with affections of the joints after gonorrhœa, the appearance of recurrent keratitis.

Cheatham, W. *Inoculation for Pannus, with a Case.* Amer. Practitioner, February, 1882. The inoculation was made of pure gonorrhœal matter. Before treatment there was but little more than perception of light—after the inflammation had subsided V = $\frac{10}{200}$ Burnett.

Pfluger. *Traumatic Herpes of the Cornea.* Conf. f. c., p. 28. What Pfluger understands by traumatic herpes of the cornea is an eruption of vesicles upon the cornea of elderly people. It has the appearance of ordinary herpes vesicles. All the patients had previously been operated upon. Pfluger, therefore, thinks that the irritation due to operation is a factor contributing to the development of the disease. The affection lasts from four to fourteen days.

Kroll. *Contributions to the Knowledge of Neuro-Paralytic Keratitis.* Centralbl. f. prakt. Augenheilk, 1882, p. 72. Kroll observed in a woman left-sided herpes zoster, conjunctivitis and opacity of the cornea. The perception of heat and cold was preserved in the affected parts, but perception of pressure and pain lost. There were also paresis of the abducens, and considerable dilatation of the pupil. An ulcer developed upon the cornea, making necrosis probable. Iodoform dusted into the eye, combined with a bandage, gradually brought about recovery.

Böckmann, E. *The Nature and Causes of the Corneal Affection accompanying Anæsthesia of the Trigeminus.* Bergen, 1882, 163 pages. The author subdivides his treatise into two sections, an experimental and a clinical one. After viewing the most important contributions of others on this subject, he reports the results which he arrived at after about 100 experiments upon cats. In all essential points they agree with the investigations of Feuer, according to whom the corneal affection developing after intracranial division of the trigeminus must be explained as a xerosis of the cornea and xerotic keratatis resulting from it. The author lays especial stress upon the importance of repeated and accurate tests of the sensibility of the eye and its adnexa, as in this way only it can be ascertained whether or not the trigeminus has been completely divided. In the clinical part Böckmann describes a xerosis of the cornea and xerotic keratitis which frequently occur among lepers. As these processes, according to the author, are synonymous with so-called neuro-paralytic keratitis, he believes, in opposition to Bull and Hansen, that the latter disease is not rare among lepers.

Blanch. *Périsclérite Rhumatismale.* Recd. Ophth., 1882. Nos. 2 and 3. Blanch reports a case of rheumatic periscleritis. It was cured in six days by alternate instillations of atropine as eserine, and internal treatment with quinine. Marckwort.

H. R. *Massage Oculaire.* Annal. de la Soc. Med. Chir. de Liege, March, 1882. The author discusses massage of the eye according to Pagenstecher's method, and recommends this method of treatment, especially in mild cases of phlyctenular conjunctivitis and in subconjunctival hem-

orrhage, which disappears more rapidly when thus treated; it is also useful in hypopyon and hyphæma. Marckwort.

Coomes, Martin F. *Osseous Degeneration of the Eye.* Med. Herald, March, 1882. The degeneration was the result of an inflammation of the uveal tract, occurring during childhood. The hyaloid and choroid was transformed into a bony shell, with an opening corresponding to the optic nerve entrance, with a diameter of one-twentieth of an inch. The anterior portion had points of chalk deposit. Burnett.

Goldzieher. *On Disseminated Choroiditis.* Wien. Med. Bl., No. 10, p. 302, and Pesth. Med. Chir. Presse. Meeting of March 4. The author thinks that the genetic and anatomical relation between disseminated choroiditis and retinitis pigmentosa is closer than has heretofore been supposed to be the case, the latter affection being nothing else than a form of chronic plastic choroiditis. The pigment in retinitis pigmentosa originates in the choroid. See below, under vitreous body.

Little, W. S. *Remarks on Persistent Hyaloid Artery.* Trans-Amer. Ophth. Soc., 1881. The Archives, vol. x., No. iii. Two cases were observed. In the second case only the tissue of the artery was preserved; no blood in the capsular membrane, but there is a little pigmented tissue in the artery.

v. Hasner. *Case of Primary Sarcoma of the Iris.* Prag. Med. Wochenschr., No. vi., p. 58, 1882. The left eye, which was the affected one, had been injured fifteen years ago, and after that slightly several times. The tumor had slowly developed in the upper-outer quadrant of the iris; its base extended from the periphery of the iris to the edge of the pupil. V=$\frac{1}{4}$. This reduction of the power of vision was probably due to secondary hyperæmia of the choroid and retina. Among thirty-two cases of sarcoma of the uveal tract two cases only were confined to the iris.

Kipp, J. C. *Two Cases of Sarcoma of the Choroid, Presenting Unusual Clinical Features.* Trans. Amer. Ophth. Soc., 1881. In both cases the tumor had grown to a considerable size without producing an increase of tension or total detachment of the retina. With the exception of these symptoms, both cases agree with the description of detachment of the choroid given in the text-book.

Agnew, C. R., and Webster, D. Report of some cases of *Glaucoma, in which an Iridectomy on One Eye Seemed to Precipitate an Attack of Acute Glaucoma of the Other.* Med. News, vol. xi., No. viii., February 25, No. 476.

Heyl, Albert G. *Acute Glaucoma Caused by Duboisia.* Amer. Jour. Med. Sci., April, 1882. The patient, a woman of fifty-five years, was already suffering from a simple glaucoma. A $\frac{2}{3}$-per cent. solution of duboisia was instilled for dilatation of the pupil for ophthalmoscopic examination. Subacute inflammatory glaucoma developed in the course of a few hours, for which an iridectomy was done with a happy result.

Mauthner. *The Excavations of the Optic Nerve.* Wien. Med. Bl., No. 10, p. 300. In this paper the author declares in favor of the theory that glaucoma is a form of serous choroiditis. It is this and not the increased intra-ocular pressure which destroys sight, those cases being known to be the worst in which T=n. Choroiditis is the primary affection, the increased pressure only a secondary symptom.

Rheindorf. *Case of Glaucoma, with Acute Opacity of the Lens.* Zeh. Klin. Monatsbl., vol. xx., 1882, p. 15. In a man with incipient senile cataract, acute glaucoma of the left eye developed, which was followed at once by opacity of the lens. The author endeavors to assign the same cause to both affections. The more the zonula is stretched by the increased intra-ocular tension, the less permeable it becomes. Thus the nutrition of the lens suffers, the consequence of which must be the rapid development of cataract.

Wagner. *Statistics of Glaucoma.* (Min. of the Meetings of the Med. Soc. of Odessa, 1881, No. 17.) Confirms the observations of Benedict, Rosa, Arlt, Ridel, Schmidt, and Kranhals, of the more frequent occurrence of glaucoma among the Jews, and seeks to explain it as a hereditary peculiarity of the race.

Critchett. *Practical Remarks on Cataract.* Ophth. Rev., vol. i., No. 4, February, 1882, p. 73, continued from p. 26. As regards an operation, the author advises not to operate upon the one until there is a marked diminution of sight in the other. But if symptoms of general constitutional degeneration are observed, it is advisable not to postpone the operation if the cataract is ripe, even though sight in the other eye may still be good, so that the chances of success later may not become worse, and safety be insured to the patients.

Galezowski. *De l'Influences des Irites et des Choroidites sur le Developpement des Cataractes.* Rev. d' Ophth., February, 1882. The lens is nourished from the aqueous humor. If disease of uveal tract affects the latter, the nutrition of the lens suffers. Galezowski discusses the cataracts which result from this; he calls them "choroiditic cataracts," and subdivides them into four classes: Choroiditis cataracts, more strictly speaking, gla-

comatous cataracts, cataracts resulting from detachment of the retina, and cataracts from retinitis pigmentosa, as the latter disease is only due to choroidal changes.

Goldzieher. *The Relation between Opacities of the Vitreous and Choroidal Affection.* Pesth Med. Chir. Presse, March 4, 1882. The vitreous body does not derive its nourishment from the chorio capillaries, but from the ciliary body, more exactly from the blood-vessels of the ciliary processes. Inflammation of the former membrane are therefore rarely attended by opacities of the vitreous; of the processes, almost always. In the serous form of choroiditis, which has its most characteristic exponent in specific choroiditis, dense and copious exudations into the vitreous are the rule. The blood-vessels nourishing the vitreous belong to the supra-choroid, and are surrounded by numerous nets of nerves and ganglion cells. The inflammatory process being conducted through these from the ciliary nerves, explains the rapid and extensive nutritive disturbance of the vitreous, as it is observed in sympathetic ophthalmia, when it manifests itself early in the form of dense opacities of the vitreous.

Angelucci. *Contribuzione allo Studio dell' Embolia dell' Arteria Centrale della Retina.* Gaz. Med. di Roma, March, 1882. Embolism of both temporal branches of the central retinal artery. In the upper branch the embolus was situated at the first fork of the artery, close to the edge of the disc; in the lower a little farther down and beyond the beginning of the nasal branch. The amaurosis had been sudden, and included the whole field of vision except a small triangle outward. Two months later the two arteries could scarcely be traced beyond the emboli. The return of large hemorrhoids and hypertrophy of the left ventricle are assigned as the cause.

Atken, Chas. *Neuro-retinitis from Blow on Forehead.* Brit. Med. Journal, February 4, 1882, p. 157. Patient was thrown out of trap, fell on right side, and was insensible for six hours. Had vomiting, epistaxis, and severe headache. On fourth day found he could not see with O. D., and was brought to Liverpool Eye Infirmary. He could read Jaeger 20. Central vision and inner field quite lost. Optic disc and retina extending to outer margin of macula much swollen and of milk-white color; veins engorged; arteries partially hidden; macula blood-red, apparently enlarged and triangular in shape; apex inward; no hemorrhages; O. S. normal. Ophthalmoscopic examination made four months later showed the optic nerve white—"remains of pigmental displacement" (sic)—arteries small; veins irregularly narrowed. Region of macula presented "washed-out-looking" patches on a deeper red ground. No perception of colors; perception of light in outer field; no central vision; muscles all acted normally; pupil sluggish; sensation normal.

Denissenko. *A Remarkable Case of Hemorrhage in the Eye.* Wien. Med. Presse, No. 1, p. 14. The globe had been squeezed by an impinging piece of wood, producing dislocation of the lens. A peculiar red spot was discovered with the ophthalmoscope at a retinal blood-vessel, which became perceptibly paler when pressure was exerted upon the globe; the blood-vessel—whether artery or vein could not be determined—seemed to enter this spot. Diagnosis: Aneurism or varix of this blood-vessel.

Hirschberg. *On Amblyopia from Iodoform Intoxication.* Sitzungsber. d. Berl. Med. Ges., March 15, 1882. C. f. A., vol. vi., p. 93. In a young girl of sixteen, upon whom a resection of the hip-joint had been performed, and who had been treated for weeks with iodoform, a central scotoma was observed, the visual field being otherwise normal, and no ophthalmascopic change visible. V.$=\frac{1}{25}$ After removal of the bandage, V. rose within eight days to $\frac{1}{2}$.

Del Monte. *Treatment of Detachment of the Retina.* Atti Dell. Ass. Ottalm. Ital., September, 1881. Ann. d'Ottalm., Vol. x., 6. Artificial leeching is useless in old cases, in recent ones even injurious. The effects of injections of pilocarpine should not be overrated. In favorable cases the effect becomes apparent after the first injection.

Schöler. *Cases of Hemianopic Defects.* Annual Rep. of his Ophthal. Clinic for 1881. Peters, 1882, p. 30, ff. 1. Left-sided homonymous hemianopia from syphilis; partial recovery. Diagnosis: gumma between the chiasm and beginning of the optic nerve. 2. Heteronymous temporal hemianopia in a person of twenty-five, with normal field of vision; without any apparent cause, only heredity; no cerebral symptoms. After the use of iodide of potash, slight change in the boundary line of the visual field. Later, incipient atrophy of the nerve was observed. 3. Left-sided hemianopia in course of recovery; cause, syphilis. Rapid improvement under inunction.

Wood-White (Birmingham). *Embolism of Arteria Centralis. Re-establishment of Circulation Witnessed with the Ophthalmoscope.* Ophth. Rev., vol. 1, No. 3, January, 1882, p. 49. A young man æt. 31, the morning of his visit to the hospital, perceived a cloud pass before his right eye, and in a few minutes the vision in this eye was totally

lost. With the ophthalmoscope the fundus presented the characteristic appearances of the embolism of the central artery. There was not the slightest perception of light. W. made pressure with his finger on the globe for the purpose of ascertaining whether there was any pulsation of the vessels, but without result. On repeating the pressure he was surprised to see the circulation suddenly re-established. The patient exclaimed that he could see. V = $\frac{20}{40}$, field of vision slightly contracted in upper part. This continued. Two days later, all œdema of retina had disappeared. V = $\frac{20}{20}$. No history of rheumatism, scarlatina or syphilis. Cardiac examination showed marked impulse, and slight systolic bruit at apex. W. thinks it was most probable that the embolus was lodged in the retinal artery at its point of bifurcation, and that not unlikely the pressure applied to the globe may have assisted in dislodging it, and that it passed forward to some peripheral portion of the retina.

Mandelstamm, E. *Injury of both Eyes by a Pistol Ball.*. C. f. A., vol. vi., p. 9. It entered at the right temple, *i. e.*, eyebrow, and passed out at the left temple near the beginning of the hair. Right side: ptosis, diminution of mobility upward, amaurosis; the ophthalmoscope showed detachment of the retina and rupture of the choroid above. Left side: no paralysis, detachment of the retina, also a rent in the choroid, and a smaller one below. Fingers counted at 8′. Total loss of the sense of smell.

Mayershausen. *Cases of Visual Disturbance After Injuries of the Skull.* (C. f. a., vol. vi., p. 44.) Fall upon the left supra-orbital region; unconsciousness, profuse epistaxis. Four weeks later atrophy of optic nerve; arteries much contracted; veins about normal; amblyopia, scotoma upward and outward. Diagnosis: Fracture of the base of the skull affecting also the roof of the orbit, resp. the optic canal; compression of the inner lower fibres of the optic nerve.

Oeller. *A Splinter of Wood.* (C. f. A., vol. vi., p. 18.) It was 8 mm. long, and had remained *in the eye seventeen and a half years without causing reaction*, as it probably had lain parallel to the longitudinal axis of the globe, behind the upper edge of the external rectus, then in consequence of an inflammation it had placed itself at right angles to its former position, had penetrated the globe, produced irido-choroiditis, and was found when extracted 8–9 mm. behind the outer edge of the cornea, at the upper edge of the external rectus, perpendicular to the longitudinal axis of the globe. Preservation of the globe and some vision.

Buzzard, I. *On Ophthalmoplegia Externa, in conjunction with Tabes Dorsalis, with Remarks on Gastric Crises.* Brain, April, 1882, pp. 34–55, 1 F., 25, double ophthalmoplegia externa with partial mydriasis (pupils 4–5 mm.), gastric crises, paroxysmal limb-pains, absence of knee reflex, etc.

Syphilis at æt. 17, 2 m., 36. Pains for five years. Decided tabetic symptoms six months; followed by ophthalmoplegia externa, quite complete; deafness and dysphagia. No optic atrophy. Death after attack of dyspnœa. Neither of the sixth nerves nor L. third nerve could be found; other cranial nerves normal. Atrophy of nerve elements, with dilatation, plugging, and rupture of minute vessels, at nucleus of origin of sixth nerve. Advanced degenerative changes in posterior columns of cord. Nuclei of the bulbar nerves normal (histological examination of Dr. Bevan Lewis). Comments on the cases.

Conti thinks he has observed a special form of *iritis from malaria* in himself and others. Atti dell' Assoc. Ottalm. Ital., September, 1881. Ann' d' Ottalm., vol. x., No. vi.

Ely, E. T. *Illustrative Cases of Disease of the Eye, Arising from Affections of the Teeth.* N. Y. Med. Record, March 11, 1882. E. relates the following cases, in which he believes the ocular troubles to depend on diseased teeth:

Case 1. Paresis of orbicularis muscle, irregular spasm of ciliary muscle, monocula diplopia.

Case 2. Paresis of R. int. rect. and ciliary muscles.

Case 3. Partial paralysis of third nerve.

Case 4. Inflammation of conjunctiva of sclera.

In all these cases the eye troubles disappeared immediately on the correction of the dental difficulty.

Possadsky. *Pathological Changes in the Retina in Some Constitutional Diseases.* Diss., St. Petersburg, 1882. 27 pages. The author reviews his pathological investigations as follows: 1. In all forms of typhoid fever there is hyperæmia of the retinal blood-vessels, and granular opacity of the 3d, 5th, 7th and 9th retinal layers (of different intensity in the different kinds of fever). 2. In chronic pneumonia, hyperæmia, hypertrophy of the connective tissue, granular opacity of the 3d, 5th and 7th layers, and occasional pigmentation of the stroma and the ganglion cells. 3. In croupous pneumonia serous infiltration of various parts. 4. In peritonitis, hyperæmia, infiltration of the tissue with white blood corpuscles, and opacity and swelling on the 3d, 5th and 7th layers. 5 and 6. Meningitis and pyæmia: hyperæmia with extravasation, blood corpuscles, infiltration of the tis-

sue, opacity of the 3d, 5th and 7th layers (less marked in pyæmia). 7. In uræmia: hyperæmia with extravasation, cellular infiltration of the tissue, slight haziness of the nervous elements. When the ureters were ligated, serous infiltration of the retina. 8. In chronic alcoholism, hyperæmia with extravasation and cellular infiltration, hypertrophy of the connective tissue, coarse granular opacity of the 3d, and fine granular opacity of the 5th and 7th layers. 9. In jaundice from cirrhosis of the liver, hyperæmia, hypertrophy of the connective tissue, and fine granular opacity of 3d, 5th, 7th and 9th layers. 10. In pleuritis with pericarditits, no changes in the retina.

Velardi and Ribozzi, who live and practice in malarious regions, have never observed ocular affections which could be brought into direct connection with the miasm. Atti dell' Assoc. Ottalm. Ital., September, 1881. Ann. d'Ottalm., vol. x., 6.

CORRESPONDENCE.

Foreign Correspondence.

BRUSSELS, *August* 3, 1883.

EDS. MED. AND SURG. REPORTER:—

The uncertainties of our glorious science have received a fresh illustration in the sickness of the Count de Chambord. This distinguished citizen is, as you know, according to the Legitimisto, Louis XIX. of France, the last direct descendant of the Bourbon dynasty. Well, he was suddenly taken sick, and for a month it was regularly announced that he was at the last gasp, in the agony, finally dead, and his will was published; and after all, now he is getting well again. The greatest physicians and surgeons were summoned from Vienna and Paris; Billroth from the former, Vulpian from the latter. But alas! they could not even decide as to the nature of the malady of the noble patient. It was cholera morbus, it was inflammation of the bowels, it was cancer of the stomach, it was suppressed gout, it was poisoning with some salt of copper or arsenic—all these, one after another, were duly reported by the various medical experts. Anyhow, the Count is getting well, and I am afraid will be hereafter a little skeptical as to medicine, however firm his faith in supra-mundane things.

You are no doubt always ready to welcome a new remedy in diphtheria; I believe one appears every month. The latest is *sulpho-cyanate of potash*. A very slight trace of this poisonous salt is found in normal saliva. Dr. Merovitsch, of St. Petersburg, noted that it is absent in diphtheritic and some other maladies supposed to be connected with a rapid development of low organisms in the economy. The suggestion naturally presented itself that this active toxic agent keeps in check the growth of germs. He administered it, therfore, in cautious doses in malignant diphtheria, and, he says, "with astonishing success." I give this statement for what it may be worth. At any rate, it is a pretty theory.

A good joke on the craniologists is just now passing around. Prof. Walcknaer has published a pamphlet on the skull, which has always passed for that of the poet Schiller. It is a large, well-balanced cranium, but by comparing its measurements with the cast of Schiller's head, taken at death, the professor proves that the skull was not his! Now, the craniologists and phrenologists have always made much of this skull as indicative of the genius of the man and as a proof of the solid truth of cranioscopy. A French paper suggests they must take refuge in the escape of the phrenologist who had demonstrated the character of Cartouche from his alleged skull, when one of his audience, pointing to another skull, exclaimed: "Why, this one is labelled *Cartouche!*"

But the lecturer was not disconcerted. "Very true, so it is, but that was his when quite a young man, this when his faculties were mature."

The public has also been regaled with an ethnological item, this time from the New World, and on the authority of an Italian physician, Dr. Pizzarello. This worthy colleague writes from the province of Tacara Tuyu, on the frontiers of the Argentine Republic and Bolivia, that he has secured a specimen of the "missing link;" a man with a genuine tail! There is a tribe of them, he says, and this one he is going to send to Europe. Perhaps the item is a hoax, and perhaps not. There was such a specimen publicly exhibited a few years ago, and reported on by Virchow and others. The "tail," however, was not a prolongation of the vertebral column, as it should have been to sustain the theory of the missing link, but merely an exaggerated fleshy growth.

To turn to a different matter, I would mention the Chelsea Hospital for Women in London. It was very recently opened, and is constructed on the most improved plans. Yet it is six stories high, although but a few years ago it was almost an axiom in hospital construction that as we increase the number of stories we increase the difficulty of sanitation in hospital wards. All that is changed by elevators, and improved methods of plumbing and ventilation. In fact, the more floors in a hospital, the cheaper is it in construction and management, and the more perfect can be made its sanitary conditions. The reasons for this are cogent, and many will readily suggest themselves on reflection. VOYAGEUR.

Answer to Queries.

EDS. MED. AND SURG. REPORTER:—

In answer to Dr. G. W. Johnson, of Savanna, Ill., in your REPORTER for August 4, 1883, I have the following statements to make:

To his first query: The clean napkins used in the case of Mrs. G. were solely and only to ascertain the continuance or not of the hemorrhage to any considerable extent.

Second. The hæmostatic properties of a tampon are purely mechanical, and it matters little whether they are introduced wet or dry. If wet, the tampon cannot absorb as much blood as when dry, just as a wet sponge cannot absorb as much water as a dry one.

Third. To this query I answer yes, in most cases, but not always. Some cases demand active treatment.

Fourth. My answer is that it is only my opinion that the local use of astringents in these cases is sheer nonsense. How can an astringent applied to the os uteri, whether open or closed, check hemorrhage from ruptured vessels within the uterine cavity? And when the uterus is open wide enough to use them, it is open wide enough to deliver the child, and in this way stop the flooding. The effects of an astringent on the vaginal walls would be a great objection to its use.

Fifth. As each case of placenta prævia is a "law unto itself," "would it not be well to leave the management of each to the attending physician?" etc. Yes, certainly, always, of course, presuming him to be well informed as to the proper management of cases of labor in general, and posted well as to the particular or special accidents that attend placenta prævia.

Sixth. The pathological lesion called "abscess of the heart," was simply a misprint (see errata in the issue of M. & R., August 4,) or careless writing, the fault being that of the printer or my own in not writing clearly.

With thanks for the interest manifested in the article by Dr. Johnson and by others, who have privately thanked me for the article, and made further inquiries about it,

T. Curtis Smith, M. D.

Aurora, Ind., August 7, 1883.

News and Miscellany.

British Medical Association.

The fifty-first annual meeting began its session in Liverpool, July 31. The retiring President, Dr. Strange, addressed the Society as follows:

Gentlemen: A writer of the last century, more terse and sententious than most of those of to-day, has said that two of the chief duties of man are "to live honestly, and to die gracefully."

The twelvemonth-long official life of your President, although a most honorable one, is yet not free from anxieties. So that, although a natural ambition may have prompted him to accept the high honor of it, when tendered by your hands, the experience of its anxieties and responsibilities will, in all probability, induce him, when his period of office is about to terminate, gracefully if he can, but certainly willingly, to transfer the sceptre to another.

This feeling would induce me to be brief in my farewell address to you to-day, even if I did not feel, as I do, the impropriety of trenching upon time which properly belongs to my successor. But, gentlemen, the thankfulness which I feel for the high honor you did me last year, and the respect due to you as my constituents, demand that, in relinquishing my office, I should give you some short account of my stewardship.

Last year, a great, a successful, and even a triumphant association, returned to the place where, fifty years before, it had emerged with fearful and timid steps, and yet with hope and promise of future greatness. How that promise has fructified, you saw at our gathering last year. Anxious minds, I assure you, presided over that jubilee of our Society, as others had done over its birth. Doubtful of possessing the power and ability to show you that welcome and hospitality which the great occasion required at our hands, I and my colleagues, short-handed enough, undertook a work which I even now fear was performed but very imperfectly. But, for whatever imperfections we might show, I knew we should have your kind and considerate forbearance. We did our best; and if that best was small, it will form the greater foil to the far larger provisions for your instruction and entertainment made by our successors in this great city.

But one good result, I am glad to think, has come out of our efforts at Worcester. Already other towns, not much larger than ours, are in the field, anxious, before long, to welcome you; and so, I trust, it will be that alternately we shall meet at such great centres of energy and wealth as this of Liverpool, and in the learned retirement of the classic muse, or in some quiet rural capital.

The most interesting subject which has engaged our attention during the year is the reform of the governing Council of the Association. This subject has arisen out of the fact that the Association has now arrived at years of maturity; has succeeded to a splendid fortune; and thinks it is time to take possession of it. Like a noble ship which has escaped many shallows, and weathered many storms, she now rides freely on the ocean, and proceeds on her prosperous course. No wonder that the crew are desirous of taking the management of her into their own hands, and of relieving of their charge those who, from the first, have piloted her and guided her in the troublous period of her early voyages. And I do not doubt, gentlemen, that it is with feelings of deep gratitude for their past services that you now relieve these Nestors of their charge.

A new scheme for your government has been sketched out by the Committee of Council; it has been laid before the Council and adopted by it, and it will be recommended for your approval to-day. It will be for you to judge of its fairness, of its comprehensiveness, and of its fitness for the present condition of the Association. And let it not be supposed, gentlemen, that this question of your government is a trivial matter. For myself, I recognize most heartily that the first and greatest object of our associated life is, and ought to be, the pursuit of knowledge and the dissemination of truth. And, whilst I envy the man who inaugurated it, I yet delight in such work as was so auspiciously begun three years ago, at the Cambridge meeting, by my friend, Professor Humphrey. Nevertheless, we must not forget that a good form of government is essential to the success even of the scientific work undertaken by us; for, unless every man's equal rights be recognized in a democratic society like ours, there will be no peace for its rulers, nor any confidence in their measures.

Gentlemen, the years to come are full of hope and promise. May I venture upon one piece of advice. Let us settle all disputed points now; so that perfect harmony, resulting from perfect satisfaction, may reign over all our future deliberations. In this way with medical science and medical art be afforded that peaceful atmosphere and that undisturbed soil in which alone they can take root and thrive.

To all matters affecting your interests, more particularly those concerning the reform of the Council, I have devoted my time in no grudging manner. It is, I conceive, the duty of your President not to be content with the honors and duties of the week of his meeting, but to take an intelligent interest in all your affairs, to watch over your interests as the one man specially elected to do so; and these, to the best of my ability, I have endeavored to do.

I have now, on bidding you farewell, great pleasure in ceding this chair to one who, I feel assured, will fill it with dignity and impartiality—one whom the profession in this great city has chosen for their leader, and whom you are now waiting anxiously to hear; and one to whom, I am sure, I may pledge myself that every one of the hundreds or thousands present at this great meeting will delight to do honor.

The following were the most prominent addresses delivered:

"The Present Aspect and Future Prospects of Medicine," by Dr. A. T. H. Waters, of Liverpool.

"Some Recent Advances in the Surgery of the Urinary Organs," by Reginald Harrison, of Liverpool.

"On the Autonomous Life of the Specific Infections," by Dr. Charles Creighton.

"The Question of Food in Obstetric and Gynecological Practice," by Dr. Graily Hewitt.

"The Structure of the Animal Cell," by E. H. Schäfer.

"An Address in the Section of Pathology," by Dr. T. Henry Green.

"General Hospitals and Hospitals for the Insane," by Dr. Thomas Lawes Rogers.

"A Survey of the Literature of the Diseases of Childhood," by Samuel Gee, M. D.

"Recent Progress in Otology," by Dr. George P. Field.

From time to time we will give an editorial summary of all that is new and valuable in these papers.

The Tri-State Medical Society

Will meet in English's Hall, at Indianapolis, on the 18th, 19th, and 20th of September, 1883, commencing at 9 a. m.

Excursion rates have been secured on the following railroads: C., C., C. & I.; Cin. Indianapolis, St. Louis & Chicago; Cin., Wabash & Mich.; Indianapolis & St. Louis; I., B. & W.; Wabash, St. Louis & Pacific; Indianapolis & Vincennes; J., M. & I.; Pitts., Cin. & St. Louis; Vandalia, Evansville & Terre Haute; Ft. Wayne, Cin. & Louisville.

HOTEL ACCOMMODATIONS.

The New Denison, Grand, Bates and Brunswick, have reduced their rates for the occasion, and everything promises a very large attendance. Many papers of great interest will be presented. For further particulars address Thos. B. Harvey, M. D., Indianapolis, Chairman of Committee of Arrangements.

G. W. Burton, M. D., Secretary, Mitchell, Ind.; Wm. Porter, M. D., President, St. Louis, Mo.

Editorial Change.

Dr. L. S. McMurtry has retired from the Louisville *Medical News*, and is succeeded by Dr. H. A. Cottell, formerly an editor of the same journal.

OBITUARY NOTICES.

DR. ARCHAMBAULT.

Dr. Archambault died in Paris, July 14, in the sixty-first year of his age, after a long and painful illness. Dr. Archambault was Physician to the Hospital for Children, in which branch of medicine he excelled. He had acquired a certain reputation for success in tracheotomy, not so much as a skillful operator as for his diagnostic powers, and for the opportuneness of the cases he selected for the operation.

FILIPPO PACINI.

The great Italian physician is dead. This versatile physician was born at Pistoia, near the site of Catiline's defeat and death, on May 25, 1812. His earliest studies were prosecuted in the Seminario of his native town, and his maturer ones in the Liceo Forteguerri. Well grounded in literature, mathematics, and philosophy, he proceeded to qualify himself for the medical career, first in the local school of Pistoia, and thereafter in the University of Pisa. From this he passed to Florence, where he devoted himself with ardor to clinical observation and research in the "Arcispedale di Santa Maria Nuova." He filled in turn the posts of Professor of Descriptive Anatomy in the Reale Liceo of Florence; of Artistic Anatomy in the Florentine Accademia delle Belle Arti; and, finally, Professor of Topographical and Microscopic Anatomy in the same seat of learning, while he also directed the anatomical studies of the Medico-Chirurgical School of the Reale Instituto di Studii Superiori.

His death, in Florence, on July 9, was hardly unexpected, as for more than a month his health had been visibly failing. He was followed to the grave by devoted friends and pupils, including the chief representatives of literature, art, and science in the Tuscan universities.

Personal.

—Mr. Jonathan Hutchinson has resigned his position as senior surgeon to the London Hospital School, and has been appointed Emeritus Professor of Surgery.

Items.

—At the recent meeting of the Medical Society of the County of Allegheny, Pa., a committee was appointed to report a plan for the efficient training of nurses in the county.

—A member of the N. E. Divorce Reform League, Mr. S. R. Dyke, states that over six thousand women die yearly in the United States from attempts to destroy unborn children.

—It appears that the Spanish government has not prohibited the importation of pork from this country, but has simply taken proper measures to prevent the entrance of diseased pork.

—The honorary degree of M. A. was bestowed upon Dr. Chas. Frederick Percival, of Baltimore, by William and Mary College at its last commencement.